ALTARUM
HEALTHCARE VALUE HUB

2022 Healthcare Affordability State Policy Scorecard

Summary Report

January 2023

ALTARUM
HEALTHCARE VALUE HUB

CONTENTS

The 2022 Healthcare Affordability State Policy Scorecards and complementary materials were created with extensive input from Hub director Beth Beaudin-Seiler; Hub manager Annaliese Johnson; Hub policy analysts Alexandra Allen, Elise Lowry and Britt Sanderson; and Hub communications leader Tad Lee. Special thanks to Lynn Quincy, Amanda Hunt, Corey Rhyan and Samuel Obbin, as well as the RAND Corporation and the Centers for Medicare and Medicaid Services.

All materials produced as part of the Healthcare Affordability State Policy Scorecard project, including the methodology report and scorecards for individual states, are available on our website at: www.HealthcareValueHub.org/Affordability-Scorecard

Arnold Ventures

Support for the Healthcare Affordability Scorecard project was provided by Arnold Ventures. The views expressed here do not necessarily reflect the views of the foundation.

INTRODUCTION

Though 2020 will remain notable for decades to come, 2021 also ushered in many sizable changes for the health policy landscape, albeit somewhat more quietly. The rapid development and dissemination of COVID-19 vaccines and boosters showcased the strength our healthcare system possesses when major players come together under a common goal. However, the roll-out also highlighted inequities in access to different types of care across communities, as individuals continued to struggle with the high cost of coverage and care. Polling continues to show that healthcare affordability remains a top issue that consumers on both sides of the political aisle want their policymakers to address.[1] Additionally, survey data collected throughout the past two years at both the state and national levels show that people continue to delay or forgo coverage and care due to cost; when they do get needed care, people often struggle to pay the resulting expense. These affordability burdens affect more than 50% of adults in some states and are present across the income spectrum.[2] This serves as a strong call for action that must be met with a comprehensive approach in order to improve healthcare affordability for all.

The Altarum Healthcare Value Hub's third iteration of the Healthcare Affordability State Policy Scorecard examines states' performance on a broad set of actions to make healthcare more affordable and allows users to: (1) do a quick and easy assessment of actions their state has already taken and (2) identify actions policymakers can take. Perhaps most importantly, the Scorecard shows the robust policy toolset that policymakers have available to address healthcare affordability by tackling the underlying drivers of affordability problems and ensuring that all residents can access coverage options with affordable premiums and cost-sharing provisions.

Unique features of the Scorecard include:

- Comprehensiveness—the Scorecard examines four domains of the healthcare affordability policy spectrum including:
  - Curbing excess healthcare prices;
  - Reducing the provision of low- and no-value care;
  - Extending affordable coverage to all residents; and
  - Ensuring that cost-sharing is affordable.
- Balance—states' scores take into account affordability-related outcomes in addition to policy efforts, giving states credit for strong outcomes even if the policy environment lacks some key actions.
- A unique dataset that compiles state-level activity with respect to both policy and outcome measures across the four healthcare affordability domains.
- Highly actionable information—each Scorecard is accompanied by an easy-to-use state Policy Checklist communicating the state's progress toward passing healthcare affordability-related policies, as well as actions policymakers still must take.[3]

This report provides case study examples of states across the country that have enacted the recommended policies and provides links to the evidence to support the recommended policies' use.

State Scorecards, as well as an Executive Summary and Methodology report, can be found at: https://www.healthcarevaluehub.org/affordability-scorecard

WHY FOCUS ON STATES?

States play an important role when it comes to making healthcare more affordable. They have the power to pass and implement policies to curb excess prices, expand coverage and limit cost-sharing for high-value care (among other interventions) and can exercise this authority to make healthcare more affordable for state residents, especially in the absence of federal action due to political gridlock and slow-moving change. Additionally, state policymakers are close to the local market conditions that influence healthcare affordability and are well-versed in their state's unique policy environment, including historic reasons for favoring or disfavoring certain policies. Altogether, states are uniquely situated to identify and take advantage of opportunities to address healthcare affordability.

Healthcare affordability is a complex issue with many moving parts. In some states, affordability problems may stem from a lack of affordable coverage, while other states may primarily grapple with high annual spending growth. As a result, the path to healthcare affordability is not a "one-size-fits-all" approach–the appropriate solutions vary depending on states' unique healthcare/health policy environments. This Scorecard recognizes this dynamic by producing a custom set of recommendations tailored to each state.

DIGGING INTO THE DATA—WHAT DID WE LEARN?

In addition to highlighting health system weaknesses, the COVID-19 pandemic also spurred policy change. Across the country, policymakers took a fresh look at many health and social policies, including coverage eligibility and cost-sharing requirements that ultimately impact affordability. While many of the temporary COVID-19 policies have expired, many states implemented permanent affordability-focused policies in areas in which they previously failed to gain traction. There have been well over 100 state level, affordability-related policy developments since our previous Scorecard was released in November 2021.

KEY FINDINGS

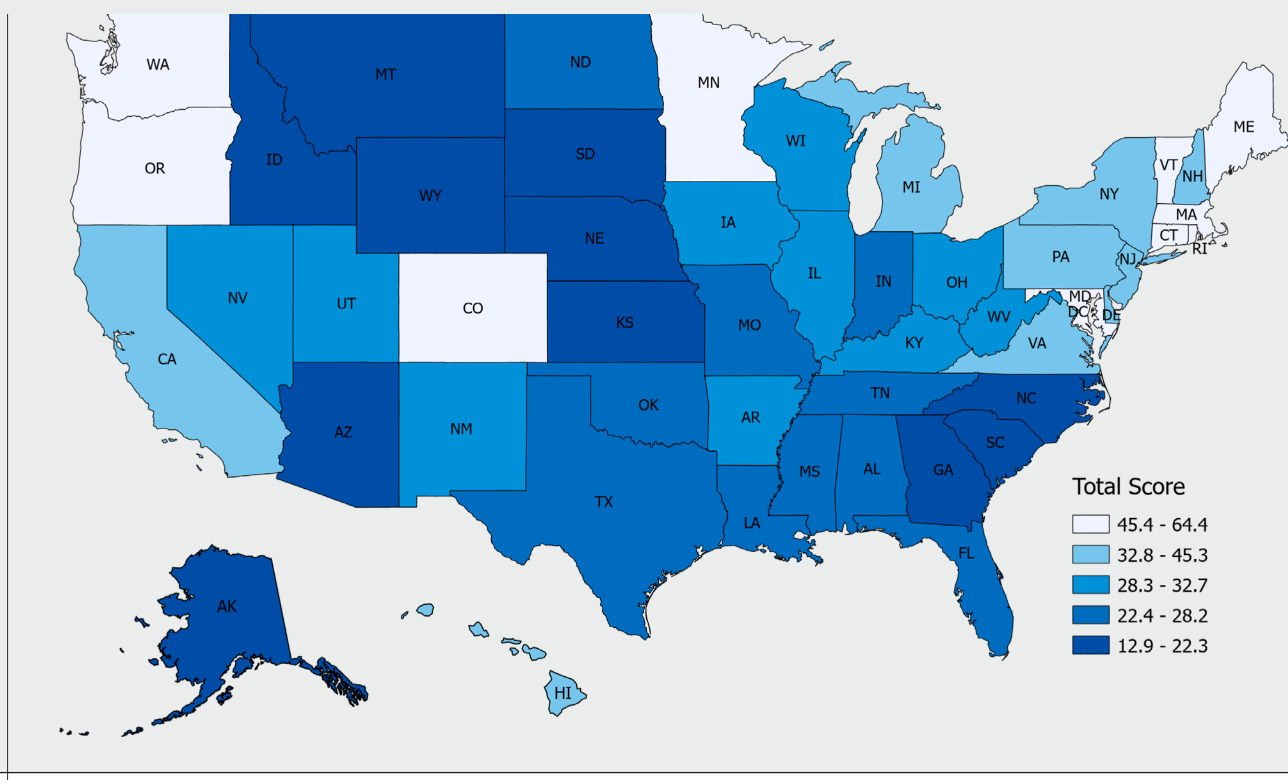
- No state earned a perfect score overall. The highest ranked state, Washington, performed well on many policy and outcome measures, but earned only 64.4 out of 80 possible points—equating to a B- grade on healthcare affordability.
- While state performance varied, the majority of states earned less than 45 out of 80 possible points, receiving an F grade on healthcare affordability.
- Our examination of policy measures to address excess prices assigned the top score to Oregon and Massachusetts, both with 10 points out of 10. However, both Maryland and Hawaii performed best in terms of outcomes (as measured by private payer inpatient and outpatient prices as a percentage of Medicare rates).[4]
- Virginia, followed by Rhode Island, was the highest scoring state for policy actions to reduce low-value care. However, Hawaii and Minnesota scored the best for outcomes, as measured by the provision of low-value care among Medicare beneficiaries.
- California was the highest scoring state for policy actions to extend affordable coverage to all state residents, with Washington, Oregon and Massachusetts tying for second place. Massachusetts scored the highest in terms of coverage outcomes (i.e., reducing the portion of the population that is uninsured),

followed by the District of Columbia. Still, more work needs to be done. Unlike the other domains, almost all states have taken one or more actions to improve access to coverage.

- California and New York scored the highest in terms of policies to make out-of-pocket (OOP) costs affordable with 10 points out of 10, followed by Connecticut. However, Vermont, followed by Delaware, scored the highest in terms of OOP cost outcomes—as measured by the percent of people who have experienced one or more of five affordability burdens: delayed seeking medical care due to cost; avoided getting medical care due to cost; made changes to prescription drugs due to cost; had problems paying medical bills; or were uninsured due to cost.

Healthcare Affordability State Ranks

The Healthcare Affordability State Policy Scorecard ranks 50 states and the District of Columbia on their adoption of evidence-based policy actions to improve healthcare affordability for residents. The Scorecard looks at both policies and outcomes across four areas that were implemented by Dec. 31, 2021.



CURB EXCESS PRICES: POLICY AND OUTCOME FINDINGS

For well documented reasons, the healthcare prices that many Americans pay are unrelated to the cost of providing those services, and often exhibit unwarranted variation and excessive profit-taking.[5] This pricing problem is particularly acute for both the uninsured and those with private health insurance (about 65% of the population). Even for people with generous, protective health coverage, high prices are embedded in the premiums they pay. A 2019 study found that roughly $230.7 billion to $240.5 billion of spending each year was associated with excess prices.[6]

A key reason for excess prices is the market power of hospitals and drug and device manufacturers. Being the only provider in an area, having all hospitals in an area owned by the same system and lack of generic drug competition are all market conditions that allow prices to rise. A 2019 report found that most Americans live in areas with concentrated healthcare markets and that consolidation has been increasing.[7] Due to the profound impact of prices on affordability and the role of market concentration, policymaker action in this area is vital.

This section of the Scorecard examined the following policy approaches:

- All-payer or multi-payer claims database (APCD);
- All-payer health spending benchmarks;
- A permanently convened health spending oversight entity; and
- Free, public-facing healthcare price transparency that reflects negotiated rates and displays prices that are treatment- and provider-specific

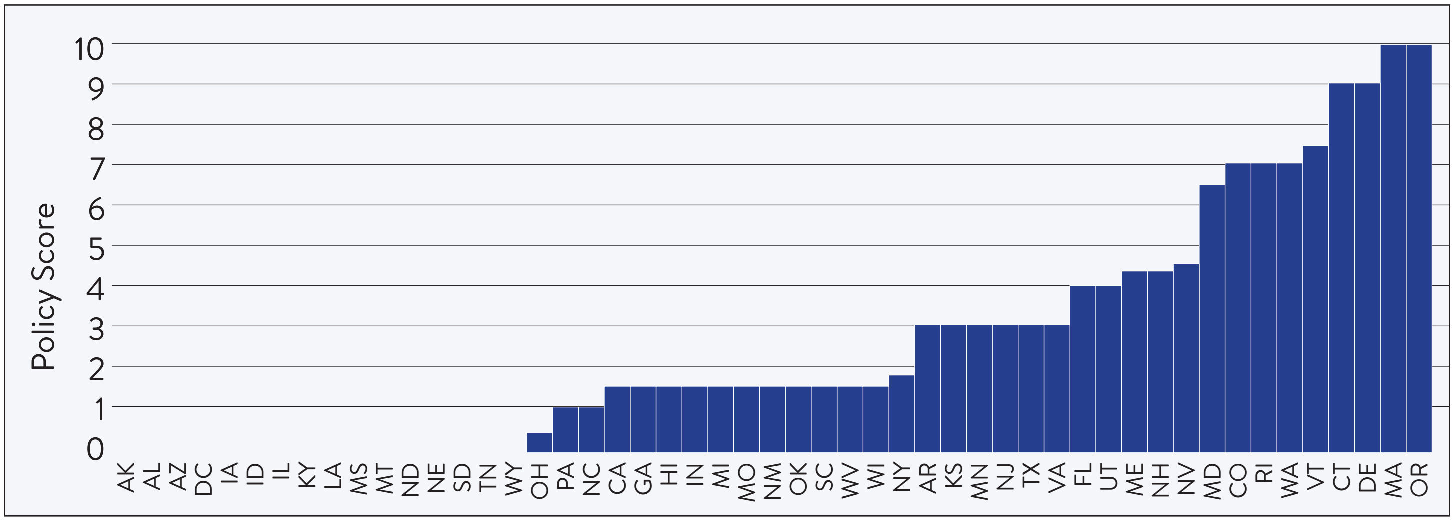
Outcome scores for this category examine each state's combined inpatient and outpatient price versus Medicare rates—a measure known as the Private-to-Medicare Ratio (PMR)—for claims from more than 4,000 hospitals and ambulatory surgical centers in all states from 2018 to 2020.

Curbing Excess Prices was the area of greatest state inaction, with 16 states not taking a single one of the recommended actions (see Figure 1). Our examination of policy measures to address the excess prices assigned the top score to Oregon and Massachusetts, both of whom received perfect scores, followed by Delaware and Connecticut. Maryland and Hawaii both received the highest score in terms of outcomes (earning the lowest ratio of combined private payer inpatient and outpatient prices compared to Medicare's allowed amounts for the claims data studied).

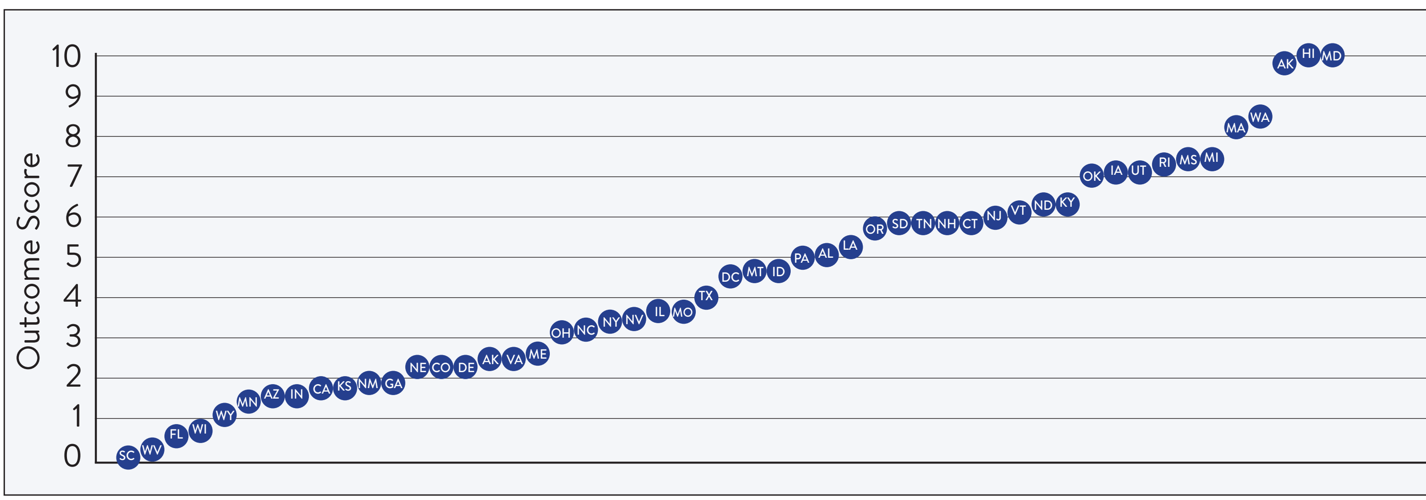
While the appropriateness of Medicare prices as a benchmark is debated, the prices are developed on a cost-basis and are adjusted based on a variety of factors (such as geographic region and hospital type), indicating that they are less affected by local market conditions that may give rise to excessive private payer prices. According to the RAND 4.0 study from which the Healthcare Value Hub drew these data, average state combined inpatient and outpatient prices were 224% of Medicare prices in 2020, with this figure remaining relatively stable over the study period.[8] Prices varied substantially by state—Florida (309%), West Virginia (318%) and South Carolina (322%) had relative prices that were at or above 309% of Medicare prices. On the other hand, Hawaii (146%), Arkansas (149%) and Washington (174%) had relative prices below 175% of Medicare prices. Although data from Maryland were excluded from the RAND 4.0 study, we estimate that the state has low prices based on their unique rate-setting system and external evidence related to its execution, therefore the state received a high outcome score in this category.[9,10]

FIGURE 1: STATE SCORE COMPARISON: CURB EXCESS PRICES

Policy Scores



Outcome Scores



Appendix A lists the Curbing Excess Prices policy scores for all states, along with the state rank for this Scorecard component.

A CLOSER LOOK AT THE RECOMMENDED POLICY ACTIONS:

All-payer or multi-payer claims databases: APCDs are large-scale databases created by states that can contain diverse types of healthcare data, including health, dental and pharmacy claims data from private insurance companies, state employee health benefit programs, Medicare and Medicaid.[11] These databases are critical tools for addressing excess prices. APCDs (or their near cousin, multi-payer claims datasets) can provide useful information on payment, utilization and disease patterns, which can be used by a wide range of stakeholders to aid in health system transformation efforts.

This was the area of greatest state policy action within the Excess Prices category, with 31 states having an active APCD or an APCD in process.[12] It is important to recognize, however, that the quality of APCDs varies substantially—some APCDs contain claims data that represents only a small portion of the state's population, while others (like New York's) provide limited and/or outdated publicly available information.

In 2020, **Colorado** developed the Data Mart project with funds from the Centers for Medicare & Medicaid (CMS). The Data Mart allowed specific users at the Colorado Department of Health Care Policy & Financing and the Department of Insurance to track members over time and across payers, as well as generate geographic analyses.[13] Because the state agencies expressed that the Data Mart was helpful in increasing their ability to use Colorado's APCD data, the Center for Improving Value in Health Care is exploring the viability of this model for other stakeholder groups.[14]

In 2021, **Nevada** passed legislation requiring the Department of Health and Human Services to establish an APCD with mandatory data submission for state-regulated insurers and voluntary submission for employer-sponsored plans, among others.[15] The state is also required to publish annual reports on the cost and quality of healthcare, including actual patient costs and prescription medication costs and utilization. The APCD is expected to go live in January 2023, although a lack of funding has led to delays.[16,17]

All-payer spending targets or benchmarks: As healthcare spending continues to increase faster than wages and the rest of the economy, establishing overall spending targets are an important tool for reigning in spending growth. Quality benchmarks, such as those being developed in Connecticut and Delaware, are also important to ensure that efforts to reduce healthcare cost growth does not negatively impact health outcomes. Another novel idea in Massachusetts is setting benchmarks to limit the growth in out-of-pocket health spending.

Only seven states had implemented this strategy as of Dec. 31, 2021: Connecticut, Delaware, Maryland, Massachusetts, Oregon, Rhode Island and Vermont. Implementation of spending benchmarks in Nevada and Washington began in 2022, with New Jersey's set to begin in 2023.

Massachusetts was the first state to create an annual cost growth benchmark to monitor total per capita healthcare spending. If the annual growth of total healthcare expenditures across all payers (public and private) exceeds the benchmark, the state's Health Policy Commission can require healthcare entities to implement Performance Improvement Plans and submit to strict monitoring. The Commission's 2021 Cost Trends Report found that total healthcare expenditures per capita grew 4.3% in 2018-2019 and 3.6% in 2017-2018—above the benchmark rate of 3.1%. However, Massachusetts' spending growth was below the national average of 4.7% in 2019.[18] Furthermore, total spending in Massachusetts declined in 2020 due to reduced use of care resulting from the COVID-19 pandemic, while commercial prices for care accelerated in that year.

In 2018, **Delaware** became the first state to both set a healthcare spending growth target and a suite of associated quality benchmarks.[19] Quality measures include: emergency department use; opioid overdose deaths and risk factors; and a suite of cardiovascular health measures. Legislation passed in Connecticut directs the Office of Health Strategy (OHS) to develop annual healthcare cost benchmarks for calendar years 2021-2025. OHS set the growth rate at 3.4% for 2021, to gradually decline to 2.9% by 2023 and hold there through 2025. The OHS must also set targets for increased primary care spending as a percentage of total healthcare spending, to reach 10% by 2025, and develop quality benchmarks across all public and private payers beginning in 2022.[20]

A permanently convened, health spending oversight entity: All states regulate some parts of their healthcare systems, but many lack a comprehensive, inter-agency, multi-payer plan to address this enormous segment of their economies. In order to systematically and comprehensively address the healthcare affordability burdens of state residents (and inform health system transformation efforts more generally), states need an entity empowered to look across various types of health and social spending, and to identify opportunities for improvement in terms of value for each dollar spent, quality short-comings and affordability problems for residents.

State oversight entities can take a variety of forms (see Table 1), but all of the states that received credit on the Scorecard monitor healthcare spending in a comprehensive and systematic way.[21] Eight states have implemented this strategy in a way that targets all spending: Colorado, Connecticut, Delaware, Massachusetts, Nevada, Oregon, Vermont and Washington. Seven other states (Maine, Maryland, New Hampshire, New York, Ohio, Pennsylvania and Rhode Island) have implemented this strategy in ways that target narrower forms of spending, such as hospital or drug spending.

This strategy typically goes hand-in-hand with establishing health spending targets. Colorado is the only state to have an oversight entity targeting all spending, but no accompanying spending targets (Washington and Nevada's spending targets were implemented in 2022, too late to receive credit in this Scorecard).

Maryland's Health Services Cost Review Commission monitors the efficiency and effectiveness of hospitals using financial data (revenue, expenditures and utilization) to inform the Commission's recommendations on global hospital spending targets, uncompensated care and community benefits.[22]

Colorado's Office of Saving People Money on Health Care works to reduce patient costs for hospital stays and expenses, improve price transparency, lower the price of prescription drugs and make health insurance more affordable.[23]

Vermont's Green Mountain Care Board (GMCB) has one of the most extensive portfolios of all the oversight entities we reviewed. The GMCB is empowered to: monitor spending and quality of care across sectors; operate the state's all-payer claims database; review health insurance rates and identify drivers of rate increases; oversee pilots and innovations; align activity across payers and make legislative recommendations.[24]

Table 1

Potential Areas of Responsibility of Healthcare Oversight Entities

Category	Description
Monitor Spending	Many oversight agencies monitor spending in all or some of the major healthcare sectors (for example, hospital spending). They may also seek to identify the underlying cost-drivers, such as unnecessary services, lifestyle factors and rising prices. Oversight authorities' abilities are greatly influenced by whether the state has an all-payer claims database.
Monitor Quality of Care/Disparities	Oversight authorities may also be responsible for monitoring quality of care received in hospitals and other settings, as well as assessing disparities in health outcomes between populations.
Recommendations	Most, if not all, oversight authorities examined here have the power to make policy recommendations and present their findings about costs and quality in an annual report to their state legislature to increase transparency.
Enforcement	Some oversight agencies go beyond data and recommendations, with power to subpoena, convene stakeholders or enforce global budgets.
Health Insurance	Some oversight authorities incorporate a dimension of health insurance review into their work. These duties range from monitoring consumer access to insurance rates, health insurance rate review and the impact of mandated benefits on insurance plans.
Pilots/Innovations	Some oversight authorities are responsible for pilots and innovations designed to improve healthcare value, including overseeing the State Innovation Model grants provided by CMS.
Aggregate Purchasing Power	States can aggregate the health spending programs they administer in support of a high-performing health system. Oversight entities can potentially oversee the coordination effort that would be needed.

Free, public-facing healthcare price transparency: It is well established that prices for the same healthcare service can differ significantly across providers—even within the same geographic area.[25] Yet, it is almost impossible for consumers and policymakers to get reliable information about this pricing landscape. While "shopping" by patients is unlikely to drive down excess prices,[26] transparent pricing data can be used by researchers, payers, regulators and legislators to identify outliers and embrace targeted solutions like reference pricing, strategic network construction, rate setting and more (though success will depend on the level of provider competition in the market). For maximum impact, healthcare price transparency tools should reflect negotiated rates and display prices that are treatment- and provider-specific. Ideally price transparency would be accompanied by consumer-friendly quality information and the website interface will have been thoroughly tested for consumer friendliness and usability; however, states were not scored on these dimensions.

Given that increasing price transparency is a broadly acceptable policy approach, we were surprised how few states scored well in this area. Just ten states received credit for this policy action: Colorado, Florida, Maine, Maryland, Massachusetts, New Hampshire, North Carolina, Oregon, Utah and Washington.

Maine's award-winning CompareMaine.org is a user-friendly healthcare transparency website and is one of the only in the nation to present quality ratings alongside cost information. Consumers can compare the costs and quality of more than 280 procedures at more than 320 facilities in the state.[27]

Maryland's "Wear the Cost" price transparency website has data for just 13 procedures, but the site uniquely shows the portion of total cost that is associated with potentially avoidable complications.[28]

Utah's Office of the State Auditor published the "Utah Health Cost Compare" tool in March 2020 to give consumers the median amounts paid by both insurance carriers and patients using claims data from insurance companies to the state's APCD.[29] The tool is a result of a 2019 state law that requires the State Auditor to create and maintain a healthcare price transparency tool that is accessible to the public.[30]

REDUCE LOW VALUE CARE: POLICY AND OUTCOME FINDINGS

Building on groundbreaking work conducted by the Institute of Medicine and Berwick and Hackbarth, a 2019 study found that approximately one-quarter of healthcare spending is wasted.[31] In other words, roughly 25 percent of healthcare spending does not result in better health. Researchers estimated that one category of healthcare waste—overtreatment/low-value care—drives $75.7 billion to $101.2 billion in health expenditures each year. The estimated annual savings from the implementation of measures to eliminate overtreatment/low-value care ranges from $12.8 billion to $28.6 billion. Failure to curtail this "waste" raises premiums and causes patients to endure unnecessary cost-sharing for services, inconvenience and, occasionally, medical harm.

Policies to reduce the provision of low-value care were difficult to assess at the state level. While the data is clear that significant spending is associated with low- and no-value care, evidence is still being developed with respect to the state policy actions that can reduce the provision of low- and no-value services.[32]

This section of the Scorecard examined the following policy approaches:

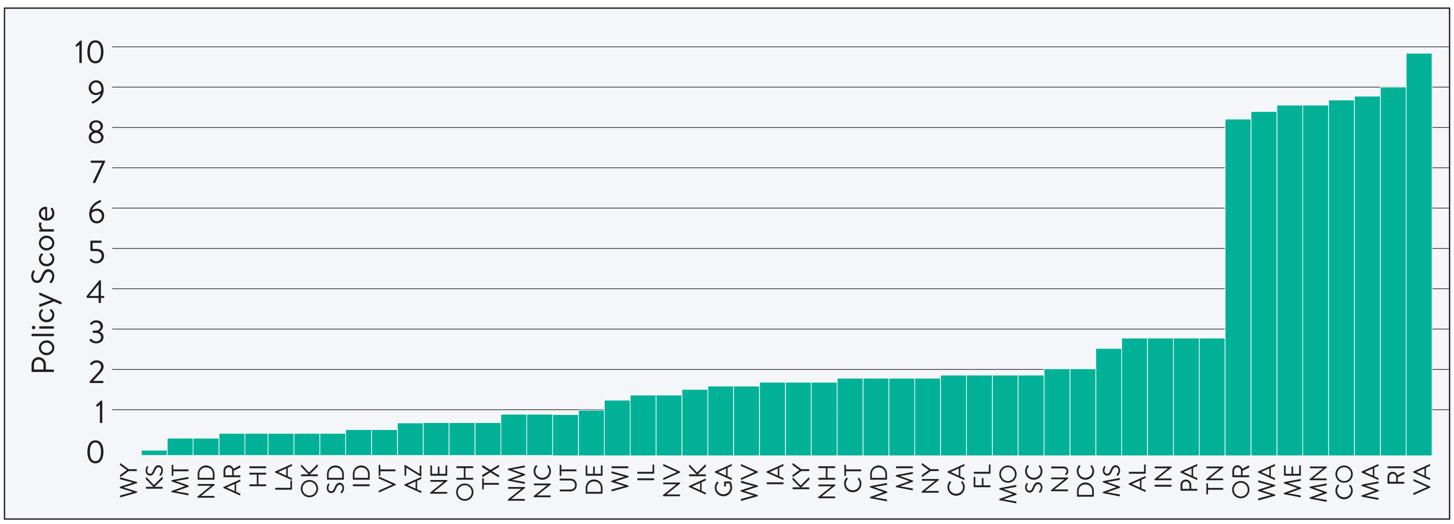
- Whether the state requires medical error reporting for two types of hospital-acquired infections—central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI)—and whether the reports are validated;
- Whether hospitals have adopted the CDC's 'Core Elements' of antibiotic stewardship; and
- Whether the state measures the provision of low-value care in claims data and/or electronic health records (EHRs).

The outcomes measure for this section of the Scorecard changed for this iteration. In 2021, we used a different metric based on the Johns Hopkins Overuse Index using 2015-2018 data, whereby the outcome was a standard deviation of each state's overuse of low-value care relative to an unknown national average. This year, however, the outcome score captures the percentage of Medicare beneficiaries in each state who received one or more low-value care services identified from a list of 20 low-value services.[33,34] State scores reflect how each state performs, relative to the highest performing state—states with lower percentages of adults receiving low-value care services received higher scores (see accompanying Methodology Report for additional detail).

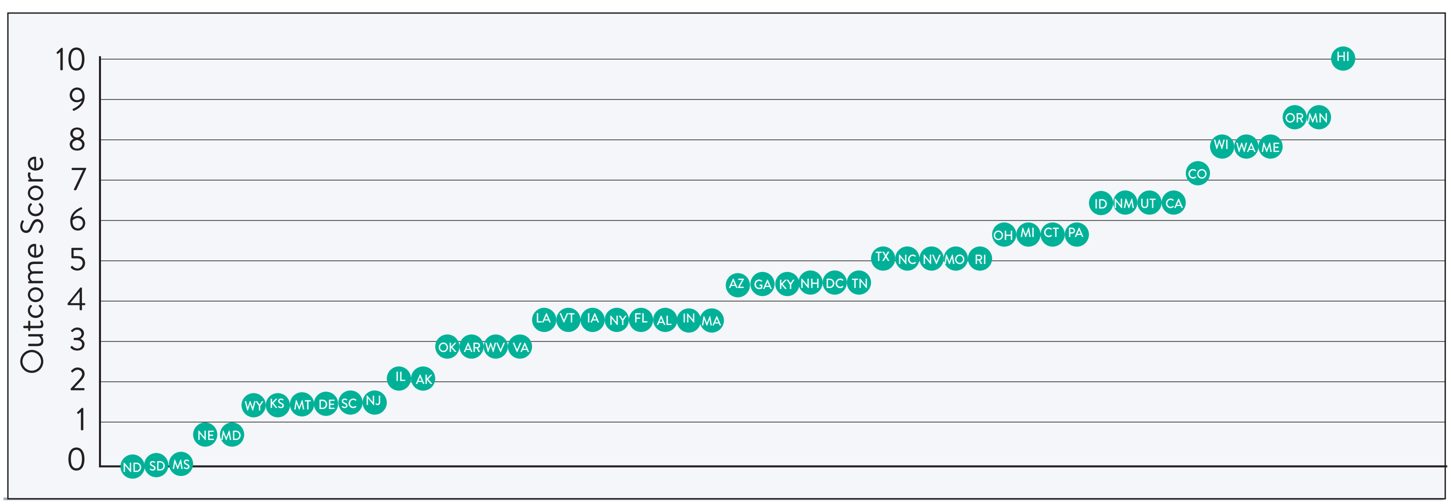
Just one state (Wyoming) had a true zero for this policy area, but eight other states (Arkansas, Hawaii, Kansas, Louisiana, Montana, North Dakota, Oklahoma and South Dakota) took actions so minimal that their policy scores would effectively round down to zero. Virginia received the highest policy score, but Hawaii (followed by Minnesota and Oregon) scored best in terms of outcomes, with the lowest percentages of Medicare beneficiaries having received one or more low-value care services (see Figure 2). Mississippi, North Dakota and South Dakota had the greatest percentage of Medicare beneficiaries having received one or more low-value care services, followed by Maryland and Nebraska.

FIGURE 2: STATE SCORE COMPARISON: REDUCE LOW VALUE CARE

Policy Scores



Outcome Scores



A CLOSER LOOK AT THE RECOMMENDED POLICY ACTIONS:

Validated reporting for medical errors. Medical harm is a particularly egregious form of healthcare waste and there is little debate about the need to increase efforts to reduce it.[35] Medical harm can take many forms, including:

- Serious Reportable Events—more commonly called "never events;"
- Healthcare-acquired conditions;
- Healthcare-acquired infections;
- Medication errors; and
- Diagnostic errors.

There are no comprehensive assessments of the total cost that medical harm adds to our nation's healthcare bill.[36] Most studies are limited to the examination of a particular type of event, a particular population or a particular healthcare setting. Nonetheless, a compilation of available studies found that around 1 in 20 (6% of) patients are affected by preventable harm in medical care, which leads to disability or death around 12% of the time. Moreover, we know that the resources devoted to prevention—by hospitals, other healthcare providers and governmental agencies at the state and federal levels—are dwarfed by the resources spent to treat the consequences of this mostly preventable problem.[37] Beyond finances, the human cost is staggering.[38]

Strategies to reduce patient harm are fairly well understood but unevenly implemented. In part, this stems from a lack of public reporting. Tracking medical harm at the state level is an important component of a comprehensive approach to improving patient safety.[39] There is broad agreement that the goal of reporting is not to "shame and blame" but to work across stakeholders to identify patterns and craft data-driven interventions that prevent future harm. Errors leading to preventable harm are almost always multifactorial.[40]

States that require reporting typically require reporting for just a few types of harm, such as selected healthcare-acquired conditions and/or healthcare-acquired infections. In this Scorecard, we used a national database that showed whether states required hospitals to report two common types of healthcare acquired infections: central line-associated bloodstream infections and catheter-associated urinary tract infections. In 2020, 28 states including DC required hospitals to report at least one of these infections.[41] We also looked at whether reports were validated, as studies have identified serious problems with under-reporting of medical harm.[42] In 2020, 13 states including DC validated reporting for at least one of these infections.[43]

Antibiotic stewardship in acute care hospitals: According to a national analysis, at least 30% of antibiotics prescribed in the outpatient setting are unnecessary, contributing to unnecessary spending and the rise of antibiotic resistant bacteria.[44] Most of these unnecessary antibiotics are prescribed for respiratory conditions caused by viruses—including common colds, viral sore throats, bronchitis and sinus and ear infections—which do not respond to antibiotics. State health agencies' roles in addressing this problem include coordinating and facilitating prevention activities, monitoring antibiotic resistance across the state, leveraging existing partnerships and resources, and developing policies to improve antimicrobial prescribing and use (a.k.a. antibiotic stewardship).[45]

As a means of assessing progress, this Scorecard scores states based on the percentage of the state's acute care hospitals that have adopted the CDC's 'Core Elements' for hospital antibiotic stewardship.[46] Proven benefits include protecting patients from unintended consequences, improving the treatment of infections and helping combat antibiotic resistance. State scores reflect their relative progress (vis-à-vis other states) towards 100 percent of acute care hospitals adopting the CDC's standards.[47]

Many states perform well on hospital antibiotic stewardship, with 30 states plus the District of Columbia reporting at least a 90% Core Elements adoption rate among the state's acute care hospitals. One hundred percent of hospitals in Delaware, D.C., New Jersey and Rhode Island have adopted the CDC's Core Elements, while eight states (Arkansas, Kansas, Louisiana, Montana, North Dakota, Oklahoma, Oregon and Wyoming) have a 83%-or-less adoption rate.

Measuring low-value care in claims data and/or electronic health records: For the most part, states (and even individual providers) are typically in the dark with respect to how often healthcare services depart from recommended clinical guidelines. More than 500 services have been identified as low- or no-value, according to the Choosing Wisely campaign.[48]

The first national study to examine spending on a subset of low-value health services among adults with commercial health insurance found considerable potential for cost savings. Studying insurance claims from more than 1.46 million adults, researchers found that spending on just 28 low-value medical services totaled $32.8 million during 2013.[49]

While purchasers and providers play key roles in reducing the provision of low- and no-value care,[50] there are steps that states can take to facilitate coordinated, multi-stakeholder action, including: prioritizing the reduction of low-value care; building a culture of trust, innovation and improvement; establishing a shared language and purpose; and committing resources to measurement.[51] A critical first step is to measure the extent of low- and no-value care in claims data. While not all forms of low-value care can be successfully measured using claims data,[52] researchers have found that the use of different types of low-value services generally correlate with each other, suggesting that the provision of low-value services may be driven by common factors.[53] This Scorecard finds that only eight states had taken this step as of Dec. 31, 2021: Colorado, Maine, Massachusetts, Minnesota, Oregon, Rhode Island, Virginia and Washington.

The nonprofit **Virginia** Center for Health Innovation (VCHI) analyzed claims data and found that providers in the state ordered 5.4 million services that were considered low-value, resulting in over $586 million, or $9.09 per beneficiary per month, in wasteful spending in 2015.[54] Subsequently, the VCHI received a $2.2 million grant from Arnold Ventures to create a statewide pilot aimed at reducing the provision of low-value care. The pilot will create a large- scale health system learning community and an employer task force on low-value healthcare. A latter part of the project will develop a set of consumer-driven measures.[55] Looking Ahead: In 2022, VCHI launched the Virginia Health Value Dashboard in an effort to better understand how Virginia performs in terms of delivering health value, and to determine how they can facilitate action for improvement where necessary.

In March 2020, **Colorado's** Center for Improving Value in Health Care (CIVHC) released a report analyzing spending on 48 low-value services using claims data from 2015 through 2017 for 4.1 million Coloradans. Importantly, the report highlights the specific measures that account for the majority of spending on low-value care and provides breakouts by insurance payer and geographic region. Moving forward, CIVHC plans to generate and share provider-specific data to encourage improvement at the local level.[56]

EXTENDING COVERAGE TO ALL RESIDENTS: POLICY AND OUTCOME FINDINGS

Without healthcare coverage, affording healthcare is almost impossible for the vast majority of American families. Roughly 8.3 percent of U.S. residents (27.2 million people) were uninsured in 2021. Although this is a decrease in the uninsured rate from 2020, this rate varies widely across states and by sub-population within states.[57] Health insurance makes a difference in whether and when people receive necessary medical care, where they get their care and, ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone needed healthcare or forgo it altogether.[58]

State policy decisions have a profound impact on enrollment into coverage. While outreach strategies, enrollment assistance, website design and other factors influence enrollment, this Scorecard domain focuses on policies that reduce the cost of coverage, as cost is the most frequently cited reason for being uninsured.[59] This section of the Scorecard examined the following policy approaches:

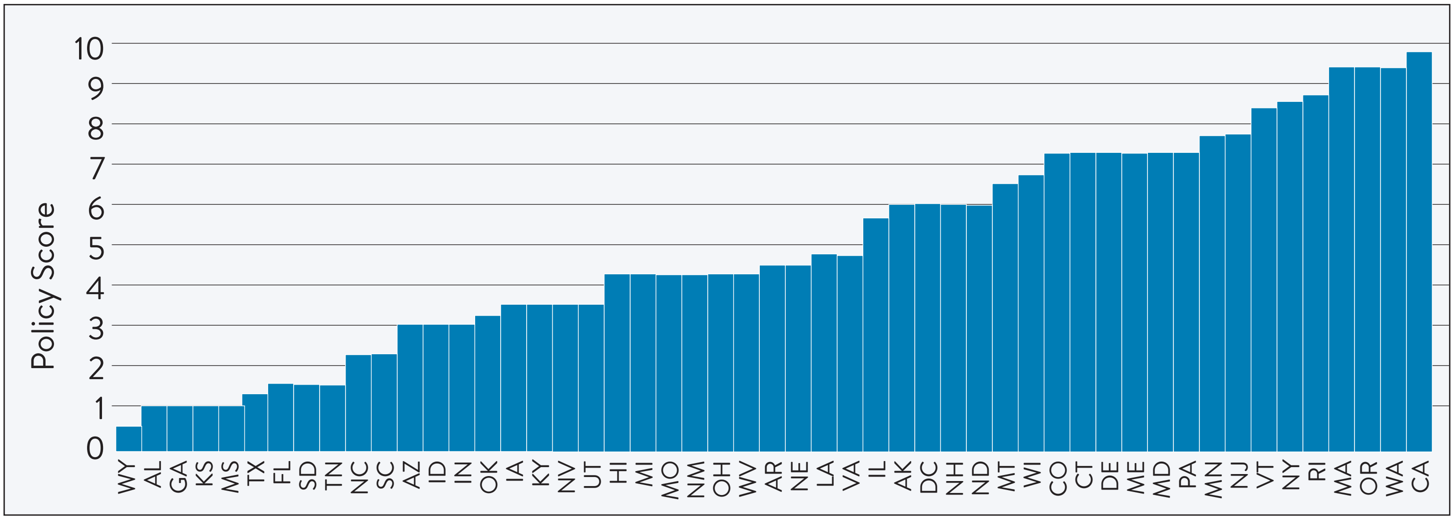
- Medicaid expansion implemented by Dec. 31, 2021;
- Supplemental premium subsidies, reinsurance, Medicaid Buy-In, Public Option, Basic Health Plan or other options for families that earn too much to qualify for Medicaid;
- Coverage options for legally residing or undocumented immigrants; and
- Health insurance premium rate review that incorporates affordability into determinations for fully insured private market coverage options.

States' *outcome* scores for this category reflect the percent of the state's population that was uninsured in 2020. States received higher scores for lower rates of uninsurance.

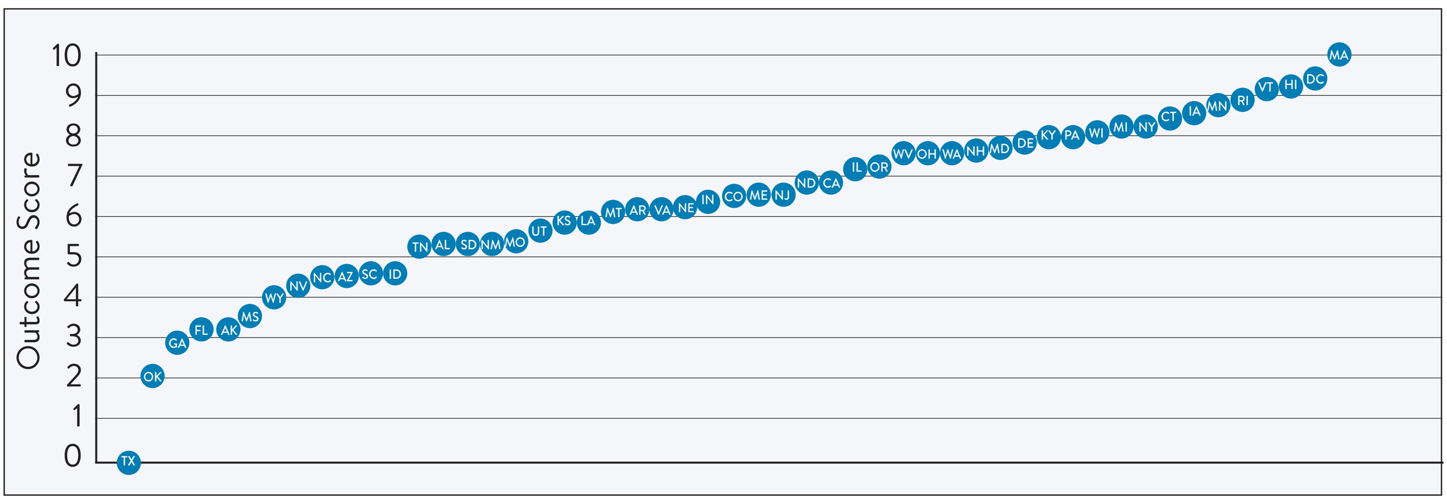
As Figure 3 shows, all states have taken one or more actions to improve access to coverage. No states scored zero points in this policy area; however, one state, Wyoming, earned less than one point (out of 10) due to an overall lack of action to expand coverage or make it more affordable. California, followed by Massachusetts, Oregon and Washington, scored highest in terms of policy actions to extend affordable coverage to all state residents while Massachusetts, followed by the District of Columbia and Hawaii, scored highest in terms of coverage outcomes (i.e., reducing the portion of the population that is uninsured).

FIGURE 3: STATE SCORE COMPARISON: EXTEND COVERAGE TO ALL RESIDENTS

Policy Scores



Outcome Scores



A CLOSER LOOK AT THE RECOMMENDED POLICY ACTIONS:

Expand Medicaid to 138% of the Federal Poverty Level: Some of the most profound disparities that exist across states affect residents with incomes below 138% of the federal poverty level (FPL).[60] Nationally, more than two million low-income, uninsured adults fall into the "coverage gap" that results from state decisions not to expand Medicaid.[61] In these states, residents with household incomes above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits face a dearth of coverage options. Strong evidence suggests that expanding Medicaid to all residents improves health outcomes, financial security and contributes to economic prosperity in a state.[62]

As of Dec. 31, 2021, 37 states had made Medicaid eligible to residents earning 138% FPL or less, and Wisconsin has made Medicaid accessible to residents up to 100% of FPL (roughly $12,880 per year for individuals and $26,500 per year for a family of 4 in 2021). The District of Columbia is a national leader in this area, extending Medicaid eligibility for single adults up to 215% of FPL (221% of FPL for parents), and Connecticut also allows adults with children earning up to 160% FPL to enroll in Medicaid. The remaining states have not expanded Medicaid, with residents falling into the so-called "coverage gap," although several of these states have made significant strides towards expanding eligibility (such as Missouri, Oklahoma and South Dakota).

> **Wisconsin** is the only state that provides Medicaid to people with household incomes up to 100% of FPL. However, research examining the population with incomes between 100-138% of FPL found that Medicaid expansion produces lower premiums and out-of-pocket costs than subsidized Marketplace coverage.[63,64]
>
> **Missouri** voters approved a ballot measure to expand Medicaid in 2020. Coverage expansion was set to begin in July 2021 but was delayed due to a lawsuit that reached the Supreme Court. The Court ruled in favor of the expansion and the state began processing applications in October 2021, with coverage backdated to July 1, 2021.[65]
>
> **Oklahoma** voters approved a Medicaid expansion initiative in 2020 and expansion took effect in 2021.[66] The state began enrolling residents under Medicaid expansion in June 2021, with coverage backdated to July 1, 2021.
>
> Voters in **South Dakota** approved a ballot measure expanding Medicaid on November 8, 2022. The state must implement expansion coverage beginning on July 1, 2023.[67]

Coverage options for residents with incomes above 138% of FPL: Many who are uninsured (as well as those who struggle to afford insurance premiums) have incomes above 138% of FPL, or $12,880 per year for an individual and $26,500 for a family of four.[68] While not as common as Medicaid expansion, states are using a variety of approaches to provide residents with incomes above Medicaid thresholds affordable coverage options. All told, 20 states have taken one or more of the following policy actions: provide supplemental premium subsidies and/or establish a reinsurance program, Medicaid Buy-In, Basic Health Plan or Public Option.

The American Rescue Plan (ARP), passed in 2021, temporarily increased the availability and amount of Federal premium assistance for consumers purchasing coverage through the Marketplaces. If made permanent, this assistance may reduce the need for reinsurance programs by sharply reducing the numbers of state residents eligible to participate. Those who would remain eligible under this scenario include high-income earners and those who are ineligible for subsidies due to reasons outside of income, such as recent immigration status (i.e. having legal permanent residency for less than five years) or the family glitch (whereby one member of the family has an offer of "affordable" employer coverage). As of this publication, the enhanced ARP premium assistance has not been made permanent, however, states that have implemented or are considering implementing reinsurance programs should monitor the situation.[69]

Reinsurance was the most common approach to reducing the cost of non-group premiums, increasing from 6 states in 2019 to 14 states in 2021. For example, **Pennsylvania's** Section 1332 waiver was approved in 2020 and the state's reinsurance program went into effect in 2021, with reimbursements beginning in 2022.[70] Reinsurance programs offer payments to health insurers to offset the costs of enrollees with large medical claims.[71]

Five states (**California, Connecticut, Massachusetts, New Jersey and Vermont**) augment Marketplace tax credit subsidies with state-provided subsidies to further lower the cost of coverage. California temporarily extended premium subsidies to individuals earning 200-600% FPL for 2020 through 2022 to increase the affordability of and expand access to coverage. Massachusetts, on the other hand, offers subsidies that greatly reduce premiums for marketplace enrollees with incomes below 300% FPL. Researchers found that this policy increased take-up of individual marketplace coverage among eligible residents by 14 to 24 percent.[72] Beginning in 2021, New Jersey's Health Plan Savings program will offer subsidies to residents with incomes up to 600% FPL, while Connecticut residents who meet income requirements will be able to pay $0 for their healthcare coverage through Access Health CT.

Two states (**New York** and **Minnesota**) have implemented a Basic Health Plan option, which gives states the ability to provide more affordable coverage for low-income residents and improves continuity of care for people whose incomes fluctuate above and below Medicaid and Children's Health Insurance Program (CHIP) eligibility levels.[73]

Washington began enrollment in a Public Option hybrid model (called Cascade Care) in 2020, with coverage effective Jan. 1, 2021. Public Option plans were available in 25 of Washington's 39 counties for plan year 2022, up from 19 in plan year 2021. Because provider rates are capped at 160% of Medicare rates, premiums are expected to decrease. However, for plan year 2022, Cascade Care Bronze plan premiums are two percent more expensive than the lowest non-standard Bronze plan on the marketplace, though many carriers report that the public option plan is their lowest priced plan in several counties. Cascade Care plans were more likely to be offered in counties where the marketplace was larger and more competitive, however premiums for the plans were lower in smaller, less competitive counties.[74,75] In order to ensure that public option plans are available in all counties, effective 2023, if there are areas of the state that still don't have public option plans available, any hospital that contracts with the state for Medicaid or public employee health benefits must contract with at least one public option plan that submits an offer.[76]

Nevada and **Colorado** both passed legislation in 2021 to establish public option plans available for enrollment—by plan year 2023 in Colorado and by 2026 in Nevada.[77,78]

Coverage for recent and undocumented immigrants: According to Kaiser Family Foundation, an estimated 20.8 million noncitizens resided in the U.S. in 2021, constituting roughly 6.4 percent of the total population.[79] Noncitizens include lawfully present immigrants, as well as those without documented status. Noncitizens are significantly more likely than citizens to be uninsured. Among the nonelderly population, 26 percent of lawfully present immigrants and 42 percent of undocumented immigrants were uninsured in 2020, compared to 8 percent of citizens.[80]

In general, lawfully present immigrants must have a "qualified" immigration status to be eligible for Medicaid or CHIP and many must wait five years after obtaining qualified status before they may enroll. Although these families include workers, they are unlikely to work in industries that offer health coverage to employees.[81] Barriers to coverage cause significant hardship for these families and harm public health.

State policy options to cover legally residing and undocumented immigrants include:

- Eliminating the five-year wait and extending Medicaid and CHIP coverage to lawfully present immigrant children and pregnant people without qualified status. In 2021, 29 states provided this option to legally residing immigrant pregnant women and children82; 6 states covered only legally residing immigrant children; and 6 states covered only legally residing immigrant pregnant women.[83]
- Providing prenatal care to women regardless of immigration status, including undocumented women, by extending CHIP coverage to the unborn child or through other avenues (21 states, 5 of which offer non-comprehensive coverage that excludes services unrelated to pregnancy).
- Providing health coverage for undocumented children (7 states).
- Using state funds to provide healthcare coverage/access options for undocumented immigrant adults, as California,[84] Illinois,[85] New York City[86] and D.C.[87] have done for selected populations.

Stronger insurance premium rate review: Rate review is the process by which state insurance regulators review health carriers' proposed insurance premiums for the coming year to ensure they are based on accurate, verifiable data and realistic projections of healthcare costs and utilization. A majority of states conduct what is termed "effective" rate review, as designated by CMS's Center for Consumer Information and Insurance Oversight. This designation reflects consideration of basic factors like medical cost trends, expected utilization of services and determinations about the reasonableness of rate increases.

However, the "effective" rate review designation does not take other important factors – like affordability, provision of high-value care or the scrutiny of provider-carrier contracts—into account. Only six states (California, Massachusetts, Oregon, Rhode Island, Vermont and Washington) consider at least one of these factors during their rate review process. Ensuring that insurer rates are affordable has a direct impact on consumers' out-of-pocket costs.[88]

Rhode Island's Office of the Health Insurance Commissioner established a comprehensive set of standards designed to encourage insurance companies and hospitals to reduce costs by creating more efficient systems, not by lowering the quality of care provided or reducing coverage. Strategies include requiring insurers to invest more in primary care providers and services, encouraging primary care practices to transform into Patient Centered Medical Homes and reducing costs through the adoption of payment reform strategies.[89]

California requires health plans to disclose information on recent cost containment efforts for all rate filings submitted in the individual and small group insurance markets to the Department of Managed Care.[90]

Oregon's Department of Consumer and Business Services has the authority to request data on insurance companies' cost containment and quality improvement efforts through rate filings.[91] Moreover, rates may not be deemed "prejudicial to the interests of the insured's policyholders."[92]

Massachusetts' Department of Insurance can require issuers to provide a detailed description of the basis upon which they pay different rates to "similarly situated" providers.[93] The state's Health Policy Commission can request and review issuer-provider contracts as part of its mandate to reduce healthcare cost growth in the state.[94]

Regulators in **Washington** state have the authority to review provider contracts—critical for learning how monopoly power might be affecting rates in local markets.[95]

Vermont requires its Green Mountain Care Board to determine whether proposed rates are affordable and promote the quality of, and access to, healthcare prior to being approved.[96] Vermont is also an 'active purchaser,' which helps keep premiums down on the exchange.[97]

In December 2020, **Delaware's** Office of Value-Based Health Care Delivery released draft affordability standards that would use rate review to enforce new targets for primary care investment, unit price growth for non-professional services and adoption of alternative payment models.[98] Draft rules were available for public comment until January 2021.

MAKE OUT-OF-POCKET COSTS AFFORDABLE: POLICY AND OUTCOME FINDINGS

Even if insurance coverage was extended to the entire U.S. population, people could still face affordability problems if cost-sharing provisions or the scope of covered services leaves them underinsured (i.e., unable to afford their share of needed care after their health plan pays the bill). The Commonwealth Fund's biennial survey reveals that 23% of insured, working-age adults were underinsured in 2022.[99] It is well established that underinsured people mimic those without coverage by forgoing needed care.[100]

State policy decisions can have a profound impact on the affordability of out-of-pocket (OOP) costs, particularly in the fully insured market.[101] This section of the Scorecard examined the following state-level policy approaches:

- Protecting consumers from inadvertent, surprise out-of-network medical bills;
- Protecting consumers from short-term, limited-duration plans;
- Waiving or reducing cost-sharing for high-value services; and
- Deploying standard plan designs in the state-based Exchange.

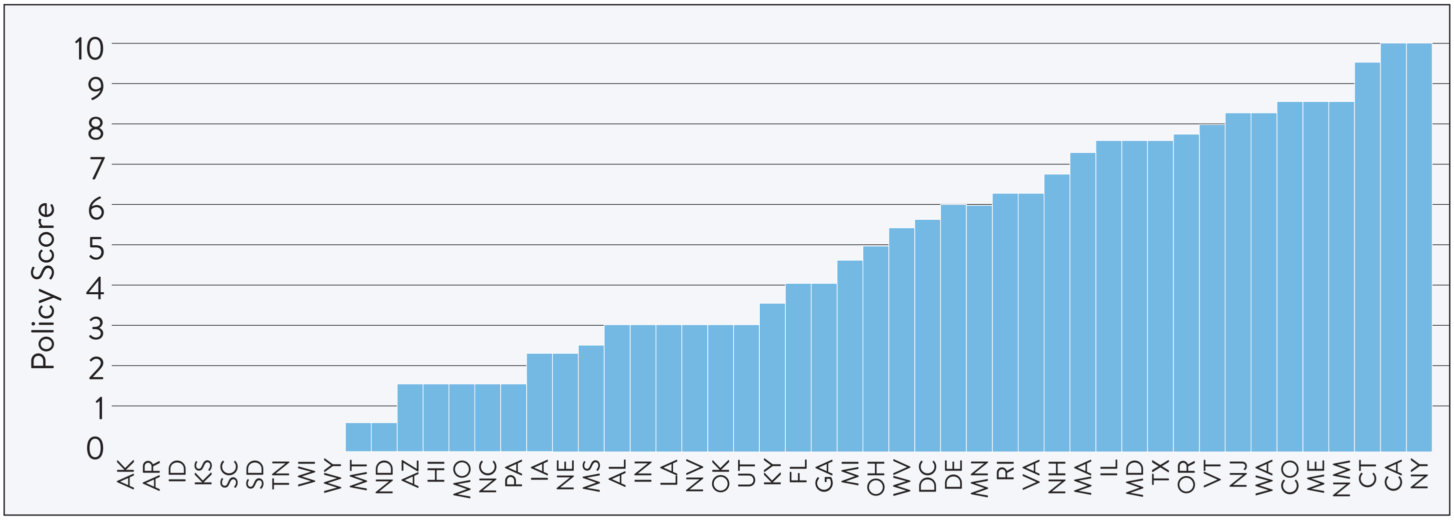
The outcome score for OOP costs examines the percent of adults who have experienced one or more of five affordability burdens: delayed seeking medical care due to cost; avoided getting medical care due to cost; made changes to prescription drugs due to cost; had problems paying medical bills; or were uninsured due to cost.

Compared to our scan of coverage efforts, we found much less policy activity designed to ease the burden of out-of-pockets costs, with nine states taking no action at all (see Figure 4). California and New York, followed by Connecticut, scored highest in terms of policy actions to make out-of-pocket costs affordable, but Vermont (followed by Delaware, New Hampshire, and Mississippi) scored highest on outcomes, meaning their residents had the lowest percentages of residents who had one or more healthcare affordability challenges.*

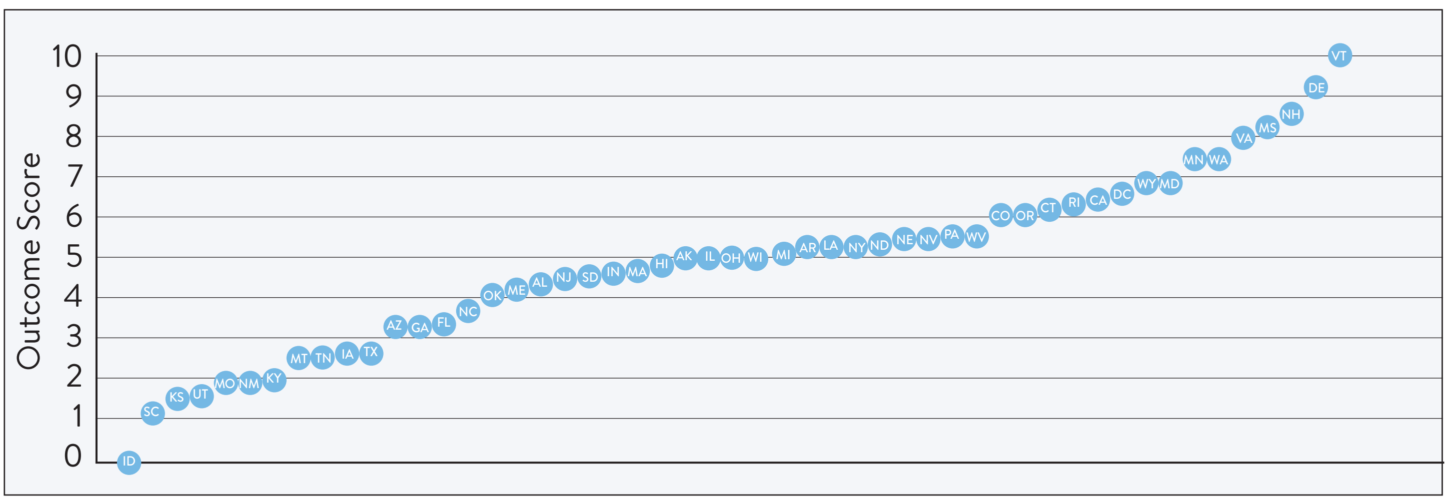
*Note: As several studies have documented, difficulty affording out-of-pocket costs can manifest itself in many ways, including foregoing needed care, delaying needed care, skimping on care (such as cutting pills in half), getting care but struggling to pay the resulting medical bills and remaining uninsured due to the high cost of insurance. The outcome score for this category assesses the prevalence of each of these actions. State-level estimates from SHADAC reveal that, even in relatively high performing states like Vermont, nearly 1 in 5 (18%) of residents reported at least one of these affordability burdens, while in worse performing states, like Idaho, more than a quarter (28%) of adults reported at least one of these affordability burdens. In some states, other surveys have found that nearly 70% of residents have recently experienced at least one of the burdens listed above.[102]

FIGURE 4: STATE SCORE COMPARISON: MAKE OUT-OF-POCKET COSTS AFFORDABLE

Policy Scores



Outcome Scores



A CLOSER LOOK AT THE RECOMMENDED POLICY ACTIONS:

Protect consumers from inadvertent, surprise out-of-network medical bills: Surprise medical bills (SMBs) include any medical bill for which a health insurer paid less than the patient expected. One form of SMB receiving a lot of attention is when patients receive a bill from an out-of-network provider that would have been difficult to avoid, for example, if they needed emergency care or received care from an out-of-network provider at an in-network hospital. These issues are particularly acute for those with private health insurance, which often features more limited provider networks and few balance billing protections, and are particularly prevalent in certain metropolitan areas, at certain institutions and for certain types of medical care.[103] The resulting expense can be financially devastating for individuals and families.

The Federal No Surprises Act, passed in 2020, prohibits surprise medical billing in most insurance plans nationwide effective January 2022. Nevertheless, states that have not already done so should consider establishing comprehensive SMB protections to (1) shore up areas unaddressed by the Federal legislation, such as ground ambulance services, which often result in surprise bills for consumers, and (2) ensure that protections will remain if the No Surprises Act is ever overturned or made less comprehensive in future legislation.

While states cannot protect consumers enrolled in self-insured plans, which are under the jurisdiction of the Federal government, they can protect consumers in fully insured plans. According to researchers at Georgetown University, state-level SMB protections must include the following components in order to be considered comprehensive:[104,105]

- Extend protections to both emergency department and in-network hospital settings;
- Apply laws to all types of insurance, including both HMOs and PPOs;
- Protect consumers both by shielding them from harm resulting from extra provider charges—meaning they are not responsible for the charges—and prohibiting providers from balance billing; and
- Adopt an adequate payment standard—a rule to determine how much the insurer pays the provider—or a dispute-resolution process to resolve payment disputes between providers and insurers.

In this Scorecard, 18 states received credit for comprehensive protections against surprise out-of-network bills and 15 states received credit for partial protections. 20 states have implemented protections against loopholes of the No Surprises Act, for services such as lab work, ground ambulances or urgent care visits.

New York was one of the first states to enact comprehensive surprise out-of-network billing protections, requiring insurers and physicians to enter binding arbitration to settle disputed medical bills. A 2017 assessment determined that the law reduced out-of- network billing by 34% and reduced the level of in-network emergency department physician payments in the state by 9%.[106] A 2019 study found that provider and insurer stakeholders view the dispute resolution process as fair, with arbitration decisions roughly evenly split between the two sides.[107] However, another 2019 assessment found that the law's guidance to arbiters (specifically that they should consider the 80th percentile of billed charges when making their determination) may be raising costs compared to a lower benchmark.[108]

Typically, state-level surprise medical bill protections do not extend to large, self-insured employers, who are regulated by the Federal government. A **New Jersey** law addressed this by allowing self-funded employers to opt in, extending state protections to employees in these plans. To opt-in, self-funded groups must: (1) provide an annual notice to the Department of Banking and Insurance which attests to being bound by the applicable provisions of New Jersey's law and (2) amend employee benefit plans, coverage policies and contracts in accordance with the law.[109]

Protect consumers from short-term, limited-duration (STLD) health plans: Short-term, limited-duration (STLD) health plans are not required to provide the standard ACA protections for nongroup coverage. Although they are relatively low cost, STLD plans cover little, can reject/charge higher rates for women and people with pre-existing conditions, are not well understood by consumers[110] and only a small percentage of the premiums collected are ultimately spent on beneficiaries' medical care.[111]

Though the term limit of these plans was capped at three months in 2016 under a ruling from the Obama administration, the Trump administration extended the limit to 364 days in 2018.[112] Some states have exercised their own authority to limit the amount of time residents can be enrolled in STLD plans and/or require STLD plan issuers to provide certain protections and benefits. For example, California, New Jersey and New York ban the sale of STLD plans altogether, while Colorado, Connecticut, the District of Columbia, Hawaii, Rhode Island, Maine, Massachusetts, New Mexico and Vermont regulate the plans so heavily that no insurers offer them in the state. Still, many states default to federal rules for STLD plans, which limit the initial plan term limit to 364 days and cap the maximum duration to 36 months.

State mandates that waive or reduce cost-sharing for high-value services: Failure to receive high-value care like flu vaccines, certain cancer screenings and other select services not only worsens health outcomes but can result in higher spending on medical care in the future.[113] Available evidence suggests that multicomponent approaches (which align financial and non-financial incentives[114] for both providers and patients) have the most success but, for the purposes of the Scorecard, we examine whether states have waived or reduced cost-sharing for high-value services to encourage utilization of high-value care. Of the 26 states that had passed policies to reduce financial barriers to high-value care as of Dec. 31, 2021, the most common area of action was capping costs for prescription drugs, particularly insulin.

New Jersey requires health plans to waive the deductible for immunizations and lead screening for children, preventive care, maternity care and second surgical opinions for people enrolled in fully insured plans.[115]

Utah's Insulin Savings Program allows any resident to purchase insulin at wholesale prices through the state and public employee plan.[116] New Hampshire caps cost-sharing for insulin to $30 for a 30-day supply for state-regulated commercial health insurance.[117]

In 2021, **California** appropriated funds to cover the portion of consumers' premiums attributable to abortion services. Because California requires plans to cover these services, but federal premium subsidies won't pay for certain abortion care, consumers eligible for $0 premium plans previously had to pay the difference, causing many to forgo insurance.[118] In 2022, California passed a law that requires all state-licensed healthcare service plans to cover abortion services without a co-pay, deductible or any other type of cost-sharing.[119]

Standard Plan Design in the state-based Marketplace: By standardizing cost-sharing obligations into a few basic plan designs, states can help consumers make better-informed coverage decisions and reduce financial barriers to high-value care. Standard benefit designs reduce the amount of variation consumers have to take into account when shopping for a health plan, making it easier to make a good selection. Standard plan designs are also the ideal vehicle for deploying evidence-based practices with respect to cost-sharing; for example, by utilizing copays, which are predictable and easier for consumers to understand, over co-insurance and avoiding high-deductible designs that create financial barriers to care for individuals with chronic health conditions or who need unexpected emergency care.[120] States can further protect consumers by requiring certain high-value services to be covered before a deductible is met and limiting copay amounts. This policy approach reduces insurers' ability to use benefit design to select favorable risk and deter enrollment by those who are sick.[121]

We find that eight states have policies aimed at lowering cost-sharing for specified healthcare services in the individual and/or small-group markets through state-prescribed standard plan designs: **California, Connecticut, the District of Columbia, Massachusetts, New York, Oregon, Vermont** and **Washington**. In most cases, standardized plans for the individual and small-group markets are similar, if not identical. The **District of Columbia** has implemented standardized plan designs that apply only to the individual market but will extend standardized plans to the small-group market beginning in plan year 2023.[122] **New York's** standardized plan design is more limited than other states' because it only provides access to prescription drugs (generic and brand name) pre-deductible.[123]

Washington implemented their standardized plans, known as Cascade Plans, in 2021. Insurers participating in the state exchange in 2021 were required to offer at least one standardized plan at both the silver and gold level, and at least one standardized bronze plan if they offered plans at that level. Legislation in 2021 simplifies the standardized plans so that there is just one at each metal level – insurers participating in the Washington exchange must offer standardized silver and gold plans, as well as a standardized bronze plan if they want to offer any bronze plan.[124]

Massachusetts, whose marketplace was the first to implement plan standardization in 2010, found that standardizing plan designs made consumers more likely to accurately differentiate among plans.[125] Uniquely, the state requires an additional layer of standardization by defining three types of provider networks ("broadest commercial," "narrow," and "tiered").[126]

Connecticut limits cost-sharing in most plans for certain high-value services, such as primary care, and limits the number of services subject to co-insurance.[127]

New Jersey's standard plans pre-date the ACA and explicitly waive the deductible for immunizations and lead screening for children, preventive care, maternity care and second surgical opinions. The state's approach varies from other states in that it legislated benefit requirements, rather than developing standardized cost-sharing requirements based on value-based insurance design principles.[128]

Oregon's standardized benefit plans include the following pre-deductible services with low to moderate copay amounts: non-preventive primary care, specialty care, laboratory and diagnostic testing, mental health and substance use disorder treatment, urgent care and generic prescription drugs.[129] Additionally, Oregon is the only state with benefit designs that feature higher cost-sharing for services that are considered overused within its educator and public employee plans.[130,131]

CONCLUSION

The Healthcare Value Hub's Healthcare Affordability State Policy Scorecard uses a unique dataset that compiles state-level activity with respect to both policy and outcomes measures across four healthcare affordability domains. The exercise shows promising movement across states in terms of both policies and outcomes, but also significant areas of inaction where states are falling short. The Scorecard reveals the robust policy toolset that state policymakers have to address healthcare affordability by tackling the underlying drivers of affordability problems—most notably, excess prices—and ensuring that all residents can access coverage options with affordable premiums and cost-sharing provisions. By providing language, a toolset and state-specific case studies, this report helps policymakers and others tie the recommended evidence-based policy actions to state residents' top priority—healthcare affordability. Moreover, the Scorecards and related products empower healthcare advocates and consumers to hold their elected officials accountable for addressing the burden of healthcare affordability.

NOTES

1 Healthcare Value Hub, *What Do Consumers Say?*, https://www.healthcarevaluehub.org/cost-and-quality-problems/what-do-consumers-say (accessed on Dec. 8, 2022).

2 Healthcare Value Hub, *Consumer Healthcare Experience State Survey*, https://www.healthcarevaluehub.org/advocate-resources/state-survey-results. See also: Robert Wood Johnson Foundation, *Healthcare Affordability: Majority of Adults Support Significant Changes to the Health System*, https://www.rwjf.org/en/library/research/2021/11/healthcare-affordability--majority-of-adults-support-significant-changes-to-the-health-system.html (accessed on Dec. 2, 2022).

3 Available by state on Healthcare Value Hub, *Healthcare Affordability State Policy Scorecard*, Washington, D.C. (2022). https://www.healthcarevaluehub.org/affordability-scorecard

4 Allen, Alexandra and Beaudin-Seiler, Beth., *Healthcare Affordability State Policy Scorecard Methodology*, Healthcare Value Hub (November 2022). https://www.healthcarevaluehub.org/application/files/8016/6723/1218/2022_Healthcare_Affordability_Scorecard_-_Methodology.pdf

5 Cooper, Zack, et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, The National Bureau of Economic Research, Cambridge MA (May 2018). https://www.nber.org/papers/w21815

6 Shrank, William H., Teresa L. Rogstad and Natasha Parekh, "Waste in the US Health Care System Estimated Costs and Potential for Savings," *JAMA* (Oct. 7, 2019). https://jamanetwork.com/journals/jama/article-abstract/2752664

7 Health Care Cost Institute, *Healthy Marketplace Index*, *https://healthcostinstitute.org/hcci-originals/healthy-marketplace-index/hmi* (accessed on Dec. 10, 2021).

8 Whaley, Christopher M., et al., *Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative, RAND Corporation*, Santa Monica, CA (2022). https://www.rand.org/pubs/research_reports/RRA1144-1.html

9 Johnson, Annaliese and Lynn Quincy, *Hospital Rate Setting: Successful in Maryland but Challenging to Replicate, Healthcare Value Hub*, Washington, D.C. (May 2020). https://www.healthcarevaluehub.org/application/files/1715/9103/4248/2020_Update_Altarum-Hub_RB_1_-_Hospital_Rate_Setting_Final.pdf

10 Data on Maryland's Private Insurance to Medicare Price Ratios are not available in the RAND 4.0 Study data, "because of Maryland's all-payer rate-setting" CMS waiver that requires equal reimbursement across all third-party payers under a global budget. This would, in theory, set our metric of the average private insurance hospital price ratio for Maryland to 100% (by far the lowest in the nation and the top-ranked state). In practice, analyses of Maryland's private insurance prices appear to be near this theoretical 100% ratio: a 2019 evaluation found an average private cost ratio for inpatient admissions at 115% of Medicare prices, and our previous Scorecard found an average price ratio among select inpatient services at 132% of Medicare. Beginning in 2019, Maryland adapted their CMS waiver to a population-based "Total Cost of Care" model, seeking not only to eliminate excessive commercial prices, but also adding "a financial incentive for hospitals to provide value-based care and to reduce the number of unnecessary hospitalizations, including readmissions." The TCOC model commits the state to a sustainable growth rate of 3.58% in per capita total cost of care spending for all payers and savings of $300 million in annual total Medicare spending for Medicare Part A and Part B by the end of 2023. As a result of this innovative and one-of-a-kind payment model in the U.S. to control prices and overall costs, Maryland receives a 10.0/10.0 in our 2022 Affordability Scorecard Outcome Score.
See: Emanuel, Ezekiel, et al., "Meaningful Value-Based Payment Reform, Part 1: Maryland Leads the Way," *Health Affairs Forefront*, (Feb. 9, 2022). https://www.healthaffairs.org/do/10.1377/forefront.20220205.211264

See also: Haber, Susan, et al., *Evaluation of the Maryland All-Payer Model, Volume I: Final Report*, RTI International, Waltham, MA (November 2019). https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf

See also: , Centers for Medicare & Medicaid Services, *Maryland Total Cost of Care Model, Baltimore, MD (June 13, 2022).* https://innovation.cms.gov/innovation-models/md-tccm

See also: Brennan, Troyen, "Maryland Hospital All-Payer Model: Can it be Emulated?" *Health Affairs Forefront, (May 31, 2022).* https://www.healthaffairs.org/do/10.1377/forefront.20220526.939479/

See also: Maryland Health Services Cost Review Commission, *Maryland's Total Cost of Care Model: Background and Summary*, Baltimore, MD (Accessed Oct. 24, 2022). https://hscrc.maryland.gov/Documents/Modernization/TCOC%20Background%20and%20Summary%20_5_23_18%20.pdf

11 Healthcare Value Hub, *All-Payer Claims Databases: Unlocking Data to Improve Healthcare Value*, Arlington, VA (September 2015). https://www.healthcarevaluehub.org/advocate-resources/publications/all-payer-claims-databases-unlocking-data-improve-health-care-value

12 California, Georgia, Hawaii, Indiana, Michigan, Missouri, Nevada, New Mexico, New York, Oklahoma, South Carolina, West Virginia and Wisconsin received partial credit for APCDs that were underway.

13 Center for Improving Value in Health Care, *2021 Colorado All Payer Claims Database Annual Report*, Denver, CO (February 2022). https://www.civhc.org/wp-content/uploads/2022/02/CO-APCD-Annual-Report-FY2020-2021.pdf

14 Ibid.

15 Nevada Senate Bill 40, 2021 Regular Session, Nevada Legislature (Accessed Nov. 15, 2021). https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7216/Overview

16 Hinton, Elizabeth, et al., *State Delivery System and Payment Strategies Aimed at Improving Outcomes and Lowering Costs in Medicaid*, Kaiser Family Foundation, San Francisco, CA (Jan. 12, 2022). https://www.kff.org/medicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-medicaid/

17 Nevada Department of Health and Human Services, *Nevada All Payer Claims Database (APCD) Procurement Plan Listening Session (Video)* (Feb. 2, 2022). https://www.youtube.com/watch?v=9uNdDAJfvZY

18 Massachusetts Health Policy Commission, *2021 Annual Health Care Cost Trends Report*, Boston, M.A. (September 2021). https://www.mass.gov/doc/2021-health-care-cost-trends-report/download

19 Odom Walker, Kara, "Can a Small State Improve Both Health Care Costs and Health Outcomes? Lessons From Delaware," *Health Affairs Blog* (June 6, 2019). https://www.healthaffairs.org/do/10.1377/hblog20190530.589329/full/

20 Connecticut Office of Health Strategy, *Cost Growth and Quality Benchmarks, and Primary Care Target*, *https://portal.ct.gov/OHS/Content/Cost-Growth-Benchmark* (accessed on Dec. 8, 2021).

21 Krishnan, Sunita, *Health System Oversight by States: An Environmental Scan*, Healthcare Value Hub, Washington, D.C. (November 2017). https://www.healthcarevaluehub.org/application/files/6815/6322/0461/Hub-Altarum_RB_20_-_Health_System_Oversight.pdf

22 Maryland Health Services Cost Review Commission, *About Us*, Baltimore, MD (accessed on Dec. 8, 2021). https://hscrc.maryland.gov/Pages/About-Us.aspx

23 Colorado Lieutenant Governor, *Office of Saving People Money on Health Care*, *https://ltgovernor.colorado.gov/programs/office-of-saving-people-money-on-health-care* (accessed on Dec. 8, 2021).

24 Krishnan, Sunita (May 2018).

25 Cooper, et al. (May 2018).

26 Quincy, Lynn and Amanda Hunt, *Revealing the Truth about Healthcare Price Transparency*, Healthcare Value Hub, Arlington, VA (June 2018). https://www.healthcarevaluehub.org/application/files/3015/6322/4395/RB_27_-_Revealing_the_Truth_About_Healthcare_Price_Transparency.pdf

27 CompareMaine, *Frequently Asked Questions (Accessed Nov. 16, 2022).* https://www.comparemaine.org/?page=about&subpage=faqs

28 Moffit, Robert E., et al., "The Next Chapter in Transparency: Maryland's Wear the Cost," *Health Affairs Blog* (Oct. 19, 2017). https://www.healthaffairs.org/do/10.1377/hblog20171023.671259/full/

29 Utah Office of the State Auditor, *Utah Health Cost Compare*, *https://healthcost.utah.gov/* (accessed on Dec. 8, 2021).

30 H.B. 178, Transparency Website Amendments, House 2019 General Session (Utah 2019). Accessed at https://le.utah.gov/~2019/bills/static/HB0178.html

31 Hunt, Amanda, *Six Categories of Healthcare Waste: Which Reign Supreme?*, Healthcare Value Hub blog (October 2019). https://www.healthcarevaluehub.org/advocate-resources/publications/six-categories-healthcare-waste-which-reign-supreme

32 Multi-stakeholder strategies, with roles for policy, providers and patients, are very promising. For more information, see Beaudin-Seiler, Beth, Lynn Quincy and Rebecca Cooper, *Reducing Low-Value Care: Saving Money and Improving Health*, Healthcare Value Hub, Arlington, VA (November 2018). https://www.healthcarevaluehub.org/advocate-resources/publications/reducing-low-value-care-saving-money-and-improving-health

33 Beaudin-Seiler, B., et al., *Estimating State-Level Prevalence of Low-Value Care Services Among the Privately Insured, Research Consortium for Health Care Value Assessment (Jan. 2020).* https://www.hcvalueassessment.org/application/files/5615/8050/0804/Research_Consortium_Research_Brief_No._2.pdf

34 Segal, Jodi B., Susan Hutfless and Aditi Sen, "Overuse Index Reported by State", Johns Hopkins University Data Archive, V1 (2021) https://doi.org/10.7281/T1/DTCK4M (note that some corrections were made to the data after publication, corrected version used in scorecard).

35 Beaudin-Seiler, Beth, et al., "Reducing Low-Value Care," *Health Affairs* Blog (Sept. 20, 2016). https://www.healthaffairs.org/do/10.1377/hblog20160920.056666/full/

36 A lack of standardized nomenclature and overlapping definitions of medical errors has hindered data analysis, synthesis and evaluation. See Rodziewicz, Thomas L., Benjamin Houseman and John E. Hipskind, "Medical Error Reduction and Prevention," *StatPearls* (January 2021). https://pubmed.ncbi.nlm.nih.gov/29763131/. To help bridge this gap, a taxonomy of medical harm is available from the Healthcare Value Hub: McGiffert, Lisa, *Medical Harm: A Taxonomy*, Healthcare Value Hub, Arlington, VA (November 2015). https://www.healthcarevaluehub.org/application/files/2315/6365/1480/Hub-Altarum_RB_9_-_Medical_Harm_Taxonomy_Final.pdf

37 Some harms cannot be avoided in clinical practice. For example, some adverse drug reactions which occur in the absence of any error in the prescription process and without the possibility of detection are less likely to be preventable. See Panagioti, Maria, et al., "Prevalence, Severity, and Nature of Preventable Patient Harm Across Medical Care Settings: Systematic Review and Meta-Analysis," *BMJ*, (July 2019). https://www.bmj.com/content/366/bmj.l4185

38 Ibid. See also, Healthcare Value Hub, *Cost & Quality Problems: Medical Harm*, https://www.healthcarevaluehub.org/cost-and-quality-problems/browse-cost-driverquality-issue/medical-harm (accessed on Dec. 8, 2021).

39 In their 1999 report, *To Err is Human*, the Institute of Medicine called for public reporting in state systems and emphasized transparency as one of 10 principles that should guide the redesign of the healthcare system. The Deficit Reduction Act of 2005 modified payment for acute-care hospitalizations of Medicare fee-for-service beneficiaries if a complicating condition occurred during the hospitalization that could have reasonably been prevented. As a result, hospitals must track and analyze instances of patient harm as a condition of participation in the Medicare program. Hospitals can demonstrate their compliance through a survey by a state survey agency or accreditation under an approved Medicare accreditation program. See Levinson, Daniel R., *Hospital Incident Reporting Systems Do Not Capture Most Patient Harm*, Department of Health and Human Services, Office of Inspector General (Jan. 5, 2012). https://oig.hhs.gov/oei/reports/oei-06-09-00091.asp

40 Bernazzani, Sophia, *Tallying the High Cost of Preventable Harm*, *https://costsofcare.org/tallying-the-high-cost-of-preventable-harm/* (accessed Dec. 10, 2021).

41 Centers for Disease Control and Prevention, *Current Healthcare-Associated Infections (HAI) progress report, Atlanta, GA (October 2021).* https://www.cdc.gov/hai/data/portal/progress-report.html#Tables. File: 2020 SIR Data > 2020 National and State HAI Progress Report SIR Data – Acute Care Hospitals > Table 1. Characteristics of NHSN Acute Care Hospitals reporting to NHSN by State1, 2020; 1a. Central line-associated bloodstream infections (CLABSI); 1b. Catheter-associated urinary tract infections (CAUTI).

42 Levinson (January 2012).

43 Centers for Disease Control and Prevention (October 2021).

44 Fleming, Katherine, E., et al., "Prevalence of Inappropriate Antibiotic Prescriptions Among U.S. Ambulatory Care Visits, 2010-2011," *JAMA, Vol. 315, No. 17* (May 2016). https://pubmed.ncbi.nlm.nih.gov/27139059/

45 Association of State and Territorial Health Officials, *Antimicrobial Stewardship*, Arlington, VA *https://www.astho.org/antimicrobial-stewardship/* (accessed on Dec. 10, 2021).

46 Centers for Disease Control and Prevention, *Antibiotic Use in the United States, 2021 Update: Progress and Opportunities, Atlanta, GA (Nov. 1, 2021).* https://www.cdc.gov/antibiotic-use/stewardship-report/current.html

47 Centers for Disease Control and Prevention, *Hospital Antibiotic Stewardship, Atlanta, GA https://arpsp.cdc.gov/profile/stewardship (accessed on Dec. 8, 2021).*

48 While not the only source for identifying low-value care, the American Board of Internal Medicine Foundation's Choosing Wisely initiative is one of the most widely recognized. The campaign aggregates recommendations from industry experts on how to reduce low-value care and distributes that information to clinicians and patients. For more information, see: https://www.choosingwisely.org/

49 Reid, Rachel O., Brendan Rabideau, and Neeraj Sood, "Low-value Health Care Services in a Commercially Insured Population," *JAMA Internal Medicine, Vol. 176, No. 10* (October 2016). https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2546154

50 Buxbaum, Jason D., John N. Mafi and A. Mark Fendrick, "Tackling Low-Value Care: A New 'Top Five' for Purchaser Action," *Health Affairs* (November 2017). https://www.healthaffairs.org/do/10.1377/hblog20171117.664355/full/

51 Beaudin-Seiler (November 2018).

52 Claims and other administrative data typically used to identify low-value care may lack the variables needed to assess the clinical nuance.

53 Schwartz, Aaron L., et al., "Measuring Low-Value Care in Medicare," *JAMA Internal Medicine* (July 2014). https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1868536

54 LaPointe, Jacqueline, "Low-Cost, Low-Value Resource Use Drives $586M in Wasteful Spending," *Revcycle Intelligence (Oct. 4, 2017).* https://revcycleintelligence.com/news/low-cost-low-value-resource-use-drives-586m-in-wasteful-spending

55 Virginia Center for Health Innovation, *Virginia Receives a $2.2M Grant to Tackle the Overuse of Unnecessary Health Care, Henrico, VA (accessed on Dec. 8, 2021). https://www.vahealthinnovation.org/2019/03/13/virginia-receives-a-2-2m-grant-to-tackle-the-overuse-of-unnecessary-health-care/*

56 Center for Improving Value in Health Care, *Low Value Care in Colorado, Denver, CO (March 2020).* https://www.civhc.org/wp-content/uploads/2020/03/Low-Value-Care-Public-Report_FINAL.pdf

57 Keisler-Starkey, Katherine and Lisa N. Bunch, *Health Insurance Coverage in the United States: 2021, United States Census Bureau, Washington, D.C. (September 2022).* https://www.census.gov/library/publications/2022/demo/p60-278.html

58 Garfield, Rachel, Kendal Orgera and Anthony Damico, *The Uninsured and the ACA: A Primer—Key Facts about Health Insurance and the Uninsured Amidst Changes to the Affordable Care Act, Kaiser Family Foundation, San Francisco, CA (January 2019).* https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/

59 Ibid.

60 Ungar, Laura, "The Deep Divide: State Borders Create Medicaid Haves and Have-Nots," *Kaiser Health News (October 2019). https://khn.org/news/the-deep-divide-state-borders-create-medicaid-haves-and-have-nots/*

61 Garfield, Rachel, Kendal Orgera and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, Kaiser Family Foundation San Francisco, CA (March 21, 2019).* https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/. See also: Gideon Lukens, *Medicaid Coverage Gap Affects Even Larger Group Over Time Than Estimates Indicate, Center on Budget and Policy Priorities, Washington, D.C. (Sept. 3, 2021).* https://www.cbpp.org/research/health/medicaid-coverage-gap-affects-even-larger-group-over-time-than-estimates-indicate

62 Guth, Madeline and Meghana Ammula, *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021, Kaiser Family Foundation, San Francisco, CA (May 6, 2021).* https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/

63 Garfield (2019). See also: Gideon Lukens, *Medicaid Coverage Gap Affects Even Larger Group Over Time Than Estimates Indicate, Center on Budget and Policy Priorities, Washington, D.C. (Sept. 3, 2021).* https://www.cbpp.org/research/health/medicaid-coverage-gap-affects-even-larger-group-over-time-than-estimates-indicate

64 Guth, Madeline, Rachel Garfield and Robin Rudowitz, *The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020, Kaiser Family Foundation, San Francisco, CA (March 17, 2020).* https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/

65 Healthcare Value Hub, *Missouri 2022 Healthcare Affordability Scorecard, Arlington, VA (November 2022).* https://www.healthcarevaluehub.org/affordability-scorecard/Missouri

66 Healthcare Value Hub, *Oklahoma 2022 Healthcare Affordability Scorecard, Arlington, VA (November 2022).* https://www.healthcarevaluehub.org/affordability-scorecard/Oklahoma

67 Kaiser Family Foundation, *Status of State Medicaid Expansion Decisions: Interactive Map, San Francisco, CA (Nov. 9, 2022).* https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

68 Healthcare.gov, *Federal Poverty Level, https://www.healthcare.gov/glossary/federal-poverty-level-fpl/ (accessed on Dec. 7, 2021).*

69 Justin Giovannelli, *A Permanent Boost to Federal Premium Assistance Could Change State Approaches to ACA 1332 Waivers, The Commonwealth Fund, New York, NY (May 3, 2021).* https://www.commonwealthfund.org/blog/2021/permanent-boost-federal-premium-assistance-could-change-state-approaches-aca-1332-waivers

70 Pennsylvania Insurance Department, *Section 1332 Waiver (Accessed Nov. 16, 2022).* https://www.insurance.pa.gov/Coverage/Pages/PA1332Waiver.aspx

71 Lueck, Sarah, *Reinsurance Basics: Considerations as States Look to Reduce Private Market Premiums, Center on Budget and Policy Priorities, Washington, D.C. (April 3, 2019).* https://www.cbpp.org/research/health/reinsurance-basics-considerations-as-states-look-to-reduce-private-market-premiums

72 Finkelstein, Amy, Nathaniel Hendren and Mark Shepard, "Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts," *American Economic Review, Vol. 109, No. 4* (April 2019). https://www.aeaweb.org/articles?id=10.1257/aer.20171455

73 Federal funding of these designs is imperiled. For more information, see King, Robert, "Health Program Proposal May Cause New York, Minnesota to Lose Millions," *Modern Healthcare* (March 2019). https://www.modernhealthcare.com/government/health-program-proposal-may-cause-new-york-minnesota-lose-millions

74 Sen, Aditi P., et al., "Participation, Pricing, and Enrollment in a Health Insurance "Public Option": Evidence from Washington State's Cascade Care Program," *The Milbank Quarterly (Nov. 23, 2021).* https://www.milbank.org/quarterly/articles/participation-pricing-and-enrollment-in-a-health-insurance-public-option-evidence-from-washington-states-cascade-care-program/?utm_content=buffer69970&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer

75 O'Brien, Madeline, *Encouraging Signs for the Public Option in Washington State: Improved Availability and Affordability of Plans in 2022, Center on Health Insurance Reforms, Washington, D.C. (Dec. 3, 2021).* http://chirblog.org/encouraging-signs-public-option-washington-state-improved-availability-affordability-plans-2022/

76 Louise Norris, *Washington health insurance marketplace 2023 guide (accessed on Dec. 8, 2022).* https://www.healthinsurance.org/health-insurance-marketplaces/washington/#standardized

77 Colorado Department of Regulatory Agencies, *Colorado Option, https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/colorado-option (accessed on Dec. 8, 2021).*

78 Messerly, Megan and Sean Golonka, "Sisolak signs bill making Nevada the second state to adopt a public health insurance option," *The Nevada Independent (June 9, 2021).* https://thenevadaindependent.com/article/sisolak-signs-bill-making-nevada-the-second-state-to-adopt-a-public-health-insurance-option

79 Kaiser Family Foundation, *Population Distribution by Citizenship Status, San Francisco, CA (Accessed Nov. 17, 2022).* https://www.kff.org/other/state-indicator/distribution-by-citizenship-status/?dataView=0&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

80 Kaiser Family Foundation, *Health Coverage of Immigrants, Washington, D.C. (April 6, 2022).* https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/

81 Ibid.

82 While Texas explicitly provides this option to children, their Unborn Child Option effectively provides non-comprehensive coverage to lawfully residing pregnant people who haven't met the 5-year bar. Because this coverage is considered non-comprehensive, Texas only gets half credit for this measure. In other states, such as Louisiana, Oklahoma, Oregon and Rhode Island, their Unborn Child Option effectively covers comprehensive coverage to lawfully residing pregnant people who haven't met the 5-year bar. Because of this, these states receive full credit for this measure.

83 Wyoming is the only state that explicitly covered just lawfully residing pregnant people without a 5-year wait. In Michigan, Missouri and Oklahoma, their Unborn Child Option effectively provides coverage to lawfully residing pregnant people who haven't met the 5-year bar. While South Dakota and Tennessee's Unborn Child Options also effectively provide coverage to lawfully residing pregnant people without the 5-year bar, this coverage is not comprehensive. As such, South Dakota and Tennessee receive half credit for this measure.

84 Healthcare Value Hub, *California 2022 Healthcare Affordability Scorecard*, Arlington, VA (November 2022). https://www.healthcarevaluehub.org/affordability-scorecard/California

85 Healthcare Value Hub, *Illinois 2022 Healthcare Affordability Scorecard*, Arlington, VA (November 2022). https://www.healthcarevaluehub.org/affordability-scorecard/Illinois

86 Healthcare Value Hub, *New York 2022 Healthcare Affordability Scorecard*, Arlington, VA (November 2022). https://www.healthcarevaluehub.org/affordability-scorecard/New-York

87 Healthcare Value Hub, *District of Columbia 2021 Healthcare Affordability Scorecard*, Arlington, VA (November 2022). https://www.healthcarevaluehub.org/affordability-scorecard/dc

88 For more information, see Healthcare Value Hub, *Improving Value: Insurance Rate Review*, Arlington, VA (Accessed Nov. 23, 2022). *https://www.healthcarevaluehub.org/improving-value/browse-strategy/rate-review*

89 Office of the Health Insurance Commissioner: State of Rhode Island, *Reform and Policy— Affordability Standards*, *http://www.ohic.ri.gov/ohic-reformandpolicy-affordability.php* (accessed on Dec. 8, 2021).

90 California Insurance Code 10181.3(c)(3). (Accessed on Nov. 23, 2022). https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=INS&division=2.&title=&part=2.&chapter=1.&article=4.5.

91 H.B. 2009, Establishing Oregon Health Policy Board, House, 2009 Regular Session (Oregon 2009). https://olis.oregonlegislature.gov/liz/2009R1/Downloads/MeasureDocument/HB2009/Enrolled

92 *Oregon Insurance Policies Generally; Property and Casualty Policies, 742.005* (Accessed on Nov. 23, 2022). https://www.oregonlegislature.gov/bills_laws/ors/ors742.html

93 Massachusetts Division of Insurance, *Health Maintenance Organizations*, https://www.mass.gov/files/documents/2016/07/xk/211-cmr-43-00-emergencycleanversion.pdf *(accessed on Dec. 7, 2021); Massachusetts Division of Insurance, Small Group Health Insurance*, https://www.mass.gov/files/documents/2017/11/08/211-66.pdf *(accessed on Dec. 7, 2021).*

94 Commonwealth of Massachusetts, Chapter 6D, Section 8, *Public hearings; Witnesses; Annual Report (Accessed on Nov. 23, 2022).* https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter6D/Section8

95 Washington Statutes (WAC 284-170-421), Provider Contracts—Standards—Hold Harmless Provisions (Accessed on Nov. 23, 2022). https://app.leg.wa.gov/wac/default.aspx?cite=284-170-421

96 Vermont Green Mountain Care Board, *Health Insurance Premium Rate Review*, Montpelier, V.T. (July 2020). https://gmcboard.vermont.gov/sites/gmcb/files/Misc/RateReview_Guide_20200715_FINAL.pdf

97 Krinn, Kelly, Pinar Karaca-Mandic and Lynn A. Blewett, "State-Based Marketplaces Using 'Clearinghouse' Plan Management Models Are Associated With Lower Premiums," *Health Affairs*, Vol. 34, No. 1 (January 2015). https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0627

98 Delaware Department of Insurance Office of Value-Based Health Care Delivery, *Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value* (Dec. 18, 2020). https://insurance.delaware.gov/wp-content/uploads/sites/15/2020/12/Delaware-Health-Care-Affordability-Standards-Report-12182020.pdf

99 As defined by the Commonwealth Fund, people who are "underinsured" have insurance coverage that does not provide them with affordable access to healthcare. This means that one of the following statements applies: Out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 10 percent or more of household income; out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 5 percent or more of a household income for individuals living under 200% FPL; the deductible constituted 5 percent or more of household income. For more information, see Collins, Sara R., et al., *The State of U.S. Health Insurance in 2022: Findings from the Commonwealth Fund Biennial Health Insurance Survey*, Commonwealth Fund, New York, NY. (Sept. 29, 2022). https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey

100 Ibid.

101 Individual, or nongroup and small-group coverage are typically regulated at the state level, whereas the coverage offered by larger employers typically takes for the form of self-insured coverage and is regulated (lightly) by the U.S. Department of Labor. Unfortunately, much of the increase in underinsurance is among those with employer coverage. Ibid.

102 Healthcare Value Hub, *Georgia Consumer Healthcare Experience State Survey*, Arlington, VA (2021). https://healthcarevaluehub.org/advocate-resources/consumer-healthcare-experience-state-survey/georgia

103 Sanger-Katz, Margot, and Reed Abelson, "Surprise! Insurance Paid the E.R. But Not the Doctor," *The New York Times* (November 2016). https://www.nytimes.com/2016/11/17/upshot/first-comes-the-emergency-then-comes-the-surprise-out-of-network-bill.html

104 Primary source augmented by additional Healthcare Value Hub review was Kona, Maanasa, *State Balance-Billing Protections*, The Commonwealth Fund, New York, NY (Feb. 5, 2021). https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections

105 To search for bills and statutes in all 50 states as they related to surprise billing regulations, see The Source on Healthcare Price & Competition, *The Database of State Laws Impacting Healthcare Cost & Quality*. https://sourceonhealthcare.org/legislation

106 Cooper, Zack, Fiona Scott Morton and Nathan Shekita, "*Surprise! Out-of-Network Billing for Emergency Care in the United States*," National Bureau of Economic Research (Revised January 2019). https://www.nber.org/papers/w23623

107 Corlette, Sabrina, and Olivia Hoppe, *New York's 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study*, Center on Health Insurance Reforms, Washington, D.C. (May 2019). http://chirblog.org/wp-content/uploads/2020/02/Georgetown_StateBased-NY-Billing_May2019.pdf

108 Adler, Loren, *Experience with New York's Arbitration Process for Surprise Out-of-Network Bills*, Brookings Institute, Washington, D.C. (October 2019). https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/

109 A.2039, *Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act, Assembly, 2018-2019 Regular Session (New Jersey 2018). Accessed at* https://legiscan.com/NJ/bill/A2039/2018

110 Gantz, Sarah, "A Philly Woman's Broken Back and $36,000 Bill Show How Some Health Insurance Brokers Trick Consumers into Skimpy Plans," *The Philadelphia Inquirer* (Nov. 14, 2019). https://www.inquirer.com/health/consumer/limited-benefit-skimpy-health-plans-sales-pitch-20191114.html

111 Pollitz, Karen, et al., *Understanding Short-Term Limited Duration Health Insurance, Kaiser Family Foundation*, San Francisco, CA (April 23, 2018). https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/

112 Pear, Robert, "'Short Term' Health Insurance? Up to 3 Years Under New Trump Policy," *The New York Times* (Aug. 1, 2018). https://www.nytimes.com/2018/08/01/us/politics/trump-short-term-health-insurance.html

113 Cooper, Rebecca, and Lynn Quincy, *High-Value Care: Strategies to Address Underuse*, Healthcare Value Hub, Arlington, VA (November 2018). https://www.healthcarevaluehub.org/advocate-resources/publications/high-value-care-strategies-address-underuse

114 Hunt, Amanda, *Non-Financial Provider Incentives: Looking Beyond Provider Payment Reform, Healthcare Value Hub, Arlington, VA (February 2018).* https://healthcarevaluehub.org/application/files/3815/6375/4940/RB_24_-_Non-Financial_Incentives.pdf

115 New Jersey Individual Health Coverage Program Board, *Standard Policy Form for the Individual Health Benefits Plan, https://www.nj.gov/dobi/division_insurance/ihcseh/ihcehbproposal1309/a50d.pdf (accessed on Dec. 8, 2021).*

116 Roe, Ginna, *Utah Health Insurer to Launch State's First-Ever Insulin Savings Program*, KUTV (May 14, 2020). https://kutv.com/news/local/utah-health-insurer-to-launch-states-first-ever-insulin-savings-program

117 Schaffer, Regina, *New Hampshire Law Caps Monthly Insulin Copay at $30, Healio* (July 17, 2020). https://www.healio.com/news/endocrinology/20200717/new-hampshire-law-caps-monthly-insulin-copay-at-30

118 Lam, T. Nancy, *State 2021-2022 Budget Benefits Health of Low-Income Californians, National Health Law Program*, (July 28, 2021). https://healthlaw.org/state-2021-22-budget-benefits-health-of-low-income-californians/

119 California Senate Bill 245, Regular Session 2022, California Legislature (Accessed Nov. 17, 2022). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB245

120 Quincy, Lynn, *What's Behind the Door: Consumer Difficulties Selecting Health Plans*, Consumers Union, Washington, D.C. (Jan 10. 2012). https://advocacy.consumerreports.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf

121 Corlette, Sabrina, et al., *Missed Opportunities: State-Based Marketplaces Fail to Meet Stated Policy Goals of Standardized Benefit Designs*, Urban Institute, Washington, D.C. (July 2016). *https://www.urban.org/research/publication/missed-opportunities-state-based-marketplaces-fail-meet-stated-policy-goals-standardized-benefit-designs-0*

122 DC Health Link, *DC Health Benefit Exchange Authority Takes Action to Achieve Social Justice and Equity in Health Insurance Coverage*, https://dchealthlink.com/node/3569 (accessed on Dec. 8, 2021).

123 Lueck, Sarah, Designing Benefit Standards for a Health Insurance Exchange, Center on Budget and Policy Priorities, Washington, D.C. (May 21, 2009). https://www.cbpp.org/research/designing-benefit-standards-for-a-health-insurance-exchange

124 *Washington Health Insurance Marketplace 2022 Guide, healthinsurance.org* (June 30, 2022). https://www.healthinsurance.org/health-insurance-marketplaces/washington/#standardized

125 Corlette, Sabrina, et al. (July 2016).

126 Massachusetts Health Connector, *Striving for Meaningful Choice: Non-Group Health Plans on the Massachusetts Health Connector Product Shelf*, Worcester, MA (January 2019). https://archives.lib.state.ma.us/bitstream/handle/2452/822485/on1140075699.pdf?sequence=1&isAllowed=y

127 Corlette, Sabrina, et al. (July 2016).

ALTARUM
HEALTHCARE VALUE HUB

128 Ahn, Sandy and Sabrina Corlette, *State Efforts to Lower Cost-Sharing Barriers to Health Care for the Privately Insured*, Urban Institute, Washington, D.C. (June 2017). https://www.urban.org/sites/default/files/publication/90961/2001311-state-efforts-to-lower-cost-sharing-barriers-to-health-care-for-the-privately-insured_0.pdf

129 Ibid.

130 National Conference of State Legislators, *Value-Based Insurance Design*, Washington, D.C. (Accessed Dec. 15, 2021). https://www.ncsl.org/research/health/value-based-insurance-design.aspx

131 Delbanco, Suzanne F., et al., *Benefit Designs: How They Work*, Urban Institute, Washington, D.C. (April 2016). https://www.urban.org/sites/default/files/publication/80311/2000777-Benefit-Designs-How-They-Work.pdf

ALTARUM
HEALTHCARE VALUE HUB

ABOUT ALTARUM'S HEALTHCARE VALUE HUB

With support from Arnold Ventures, the Healthcare Value Hub provides free, timely information about the policies and practices that address high healthcare costs and poor quality, bringing better value to consumers. The Hub is part of Altarum, a nonprofit organization with the mission of creating a better, more sustainable future for all Americans by applying research-based and field-tested solutions that transform our systems of health and healthcare.

Contact the Hub: 3520 Green Court, Suite 300, Ann Arbor, MI 48105
(734) 302-4600 | www.HealthcareValueHub.org | @HealthValueHub

Appendix A: How States Scored on Policies to Address Healthcare Affordability

State	Curb Excess Prices		Reduce Low-Value Care		Extend Coverage to All Residents		Make Out-of-Pocket Costs Affordable		Total Score (out of 80)	State Rank
	Policy Score	Outcome Score	Policy Score	Outcome Score	Policy Score	Outcome Score	Policy Score	Outcome Score		
AL	0	5.1	2.8	3.6	1	5.3	3	4.3	25.1	35
AK	0	2.5	1.5	2.1	6	3.2	0	5	20.3	45
AZ	0	1.7	0.6	4.3	3	4.6	1.6	3.3	19.1	47
AR	3	9.9	0.4	2.9	4.5	6.2	0	5.2	32.1	23
CA	1.5	1.8	1.9	6.4	9.7	6.9	10	6.4	44.6	12
CO	7	2.2	8.7	7.1	7.2	6.5	8.6	6	53.3	6
CT	9	5.9	1.8	5.7	7.2	8.4	9.6	6.2	53.8	5
DE	9	2.2	1	1.4	7.2	7.9	6	9.2	43.9	13
DC	0	4.5	2.0	4.3	6	9.3	5.6	6.6	38.3	19
FL	4	0.7	1.9	3.6	1.6	3.2	4	3.4	22.4	40
GA	1.5	1.9	1.6	4.3	1	2.9	4	3.3	20.5	44
HI	1.5	10	0.4	10	4.2	9.2	1.6	4.9	41.8	16
ID	0	4.7	0.5	6.4	3	4.7	0	0	19.3	46
IL	0	3.8	1.3	2.1	5.7	7.2	7.6	5	32.7	21
IN	1.5	1.7	2.8	3.6	3	6.4	3	4.6	26.6	32
IA	0	7.1	1.7	3.6	3.6	8.6	2.2	2.8	29.6	28
KS	3	1.8	0.1	1.4	1	5.9	0	1.6	14.8	49
KY	0	6.3	1.7	4.3	3.6	8	3.6	2	29.5	29
LA	0	5.3	0.4	3.6	4.8	5.9	3	5.2	28.2	31
ME	4.3	2.7	8.6	7.9	7.2	6.6	8.6	4.2	50.1	9
MD	6.5	10	1.8	0.7	7.2	7.8	7.6	6.9	48.5	10
MA	10	8.2	8.8	3.6	9.4	10	7.2	4.7	61.9	3
MI	1.5	7.4	1.8	5.7	4.2	8.2	4.6	5.1	38.5	18
MN	3	1.4	8.6	8.6	7.8	8.8	6	7.4	51.6	8
MS	0	7.4	2.4	0	1	3.6	2.4	8.2	25.0	36
MO	1.5	3.8	1.9	5	4.2	5.4	1.6	1.9	25.3	34
MT	0	4.7	0.3	1.4	6.6	6.1	0.6	2.6	22.3	41
NE	0	2.2	0.6	0.7	4.5	6.3	2.2	5.5	22.0	43
NV	4.5	3.5	1.3	5	3.6	4.2	3	5.5	30.6	27
NH	4.3	5.9	1.7	4.3	6	7.7	6.8	8.6	45.3	11
NJ	3	6	2	1.4	7.8	6.6	8.2	4.4	39.4	17
NM	1.5	1.9	0.9	6.4	4.2	5.3	8.6	1.9	30.7	26
NY	1.8	3.4	1.8	3.6	8.4	8.2	10	5.2	42.4	15
NC	1	3.2	0.9	5	2.2	4.5	1.6	3.7	22.1	42
ND	0	6.3	0.3	0	6	6.9	0.6	5.3	25.4	33
OH	0.3	3.1	0.6	5.7	4.2	7.6	5	5	31.5	24
OK	1.5	7	0.4	2.9	3.2	2	3	4.1	24.1	38
OR	10	5.8	8.2	8.6	9.4	7.3	7.8	6	63.1	2
PA	1	5	2.8	5.7	7.2	8	1.6	5.6	36.9	20
RI	7	7.3	9	5	8.8	8.9	6.2	6.3	58.5	4
SC	1.5	0	1.9	1.4	2.2	4.7	0	1.2	12.9	51
SD	0	5.9	0.4	0	1.6	5.3	0	4.5	17.7	48
TN	0	5.9	2.8	4.3	1.6	5.2	0	2.7	22.5	39
TX	3	4	0.6	5	1.2	0	7.6	2.8	24.2	37
UT	4	7.1	0.9	6.4	3.6	5.7	3	1.7	32.4	22
VT	7.5	6.1	0.5	3.6	8.2	9.1	8	10	53.0	7
VA	3	2.5	9.9	2.9	4.8	6.2	6.2	8	43.5	14
WA	7	8.5	8.4	7.9	9.4	7.6	8.2	7.4	64.4	1
WV	1.5	0.2	1.6	2.9	4.2	7.6	5.4	5.6	29.0	30
WI	1.5	0.9	1.2	7.9	6.8	8.1	0	5	31.4	25
WY	0	1.1	0	1.4	0.6	4	0	6.9	14.0	50

For complete methodology, detailed state scorecards and more, see: www.HealthcareValueHub.org/Affordability-Scorecard